

Bhattacharya & Ghosh, 2020; Chumakov et al., 2021; Coleman et al., 2018; Heylens, Elaut et al., 2014; Human Rights Watch, 2014; James et al., 2016; Lee, Operario et al., 2020; Luz et al., 2022; McNeil et al., 2012, 2013; Motmans et al., 2017; Muller et al., 2019; Scandurra et al., 2017; Strauss et al., 2019; Suen et al., 2017; Valashany & Janghorbani, 2019; Veale et al., 2019; Wu et al., 2017). The research shows TGD people often experience stigma and prejudice as well as discrimination and harassment, abuse and violence, or they live in anticipation and fear of such actions. Social values and attitudes hostile to TGD people, often communicated to young people in school curricula (e.g., Olivier & Thurasukam, 2018), are also expressed in family rejection (e.g., Yadegarfar et al., 2014), and perpetuated in laws, policies and practices that limit freedom to express one's gender identity and sexuality and hinder access to housing, public spaces, education, employment and services (including health care). The end result is TGD people are commonly deprived of a wide range of opportunities available to their cisgender counterparts and are pushed to the margins of society, without family supports. To make matters worse, across much of the world TGD people's access to legal gender recognition is restricted or non-existent (e.g., ILGA World, 2020a; TGEU, 2021; UNDP and APTN, 2017). In some countries, such barriers nowadays draw on support from "gender-critical theorists" (as critiqued by e.g., Madrigal-Borloz, 2021; Zanghellini, 2020).

Gender identity change efforts (gender reparative or gender conversion programs aimed at making the person cisgender) are widespread, cause harm to TGD people (e.g., APTN, 2020a, 2020b, 2020c, 2021; Bishop, 2019; GIRES et al., 2020; Turban, Beckwith et al., 2020), and (like efforts targeting sexual orientation) are considered unethical (e.g., APS, 2021; Trispiotis and Purshouse, 2021; Various, 2019, 2021). These efforts may be viewed as a form of violence. The UN independent expert on protection against violence and discrimination based on sexual orientation and gender identity has called for a global ban on such practices (Madrigal-Borloz, 2020). An increasing number of jurisdictions are outlawing such work (ILGA World, 2020b).

Inequities arise from a range of factors, including economic considerations and values underpinning the provision of health care systems, particularly with regard to the emphasis placed on public-, private- and self-funding of health care. Lack of access to appropriate and affordable health care can lead to a greater reliance on informal knowledge systems. This includes information about self-administration of hormones, which, in many cases, is undertaken without necessary medical monitoring or supervision (e.g., Do et al., 2018; Liu et al., 2020; Rashid et al., 2022; Reisner et al., 2021; Winter & Doussantousse, 2009).

In some parts of the world, large numbers of transgender women employ silicone as a means of modifying their bodies, drawing on the services of silicone "pumpers" and/or attending pumping "parties", often within their communities. The immediate results of silicone pumping contrast with significant downstream health risks (e.g., Aguayo-Romero et al., 2015; Bertin et al., 2019; Regmi et al., 2021), particularly where industrial silicone or other injectable substances have been used and where surgical removal may be difficult.

Finally, sexual health outcomes for TGD people are poor. HIV prevalence for transgender women reporting to clinical organizations in metropolitan areas is approximately 19% worldwide, which is 49 times higher than the background prevalence rate in the general population (Baral et al., 2013). Sexual health outcomes for transgender men are also problematic (e.g., Mujugira et al., 2021).

#### Statement 2.4

**We recommend translations of the SOC focus on cross-cultural, conceptual and literal equivalence to ensure alignment with the core principles that underpin the SOC-8.**

Much of the research literature on TGD people is produced in high-income and English-speaking countries. global northern perspectives about TGD people (including those related to health care needs and provision) dominate this literature. A May 2021 Scopus database search undertaken by the current authors shows 99% of the literature on transgender health care comes out of Europe, North America, Australia, or New Zealand. Overall, 96% of the literature is in the English language. TGD people of the Global

South have received relatively little attention in the English language literature, and the work of those HCPs who interact with them has often gone unrecognized and unpublished or has not been translated into English. Applying resources produced in the global north risks overlooking the relevance and nuance of local knowledge, cultural frameworks and practices, and missed opportunities to learn from the work of others.

When translating the principles set out in the SOC, we recommend following best practice guidelines for language translation to ensure high quality written resources are produced that are culturally and linguistically appropriate to the local situation. It is important translators have knowledge about TGD identities and cultures to check that literal translations are culturally competent and safe for local TGD people. It is also important translation should follow established processes for quality assurance (Centers for Medicare & Medicaid Services, 2010; Sprager & Martinez, 2015)

#### Statement 2.5

**We recommend health care professionals and policymakers always apply the SOC-8 core principles to their work with transgender and gender diverse people to ensure respect for human rights and access to appropriate and competent health care, including:**

##### *General principles*

- Be empowering and inclusive. Work to reduce stigma and facilitate access to appropriate health care, for all who seek it;
- Respect diversity. Respect all clients and all gender identities. Do not pathologize differences in gender identity or expression;
- Respect universal human rights, including the right to bodily and mental integrity, autonomy, and self-determination; freedom from discrimination and the right to the highest attainable standard of health.

##### *Principles around developing and implementing appropriate services and accessible health care*

- Involve TGD people in the development and implementation of services;

- Become aware of social, cultural, economic, and legal factors that might impact the health (and health care needs) of transgender and gender diverse people, as well as the willingness and capacity of the person to access services;
- Provide health care (or refer to knowledgeable colleagues) that affirms gender identities and expressions, including health care that reduces the distress associated with gender dysphoria (if this is present);
- Reject approaches that have the goal or effect of conversion, and avoid providing any direct or indirect support for such approaches or services

##### *Principles around delivering competent services*

- Become knowledgeable (get training, where possible) about the health care needs of transgender and gender diverse people, including the benefits and risks of gender-affirming care;
- Match the treatment approach to the specific needs of clients, particularly their goals for gender identity and expression;
- Focus on promoting health and well-being rather than solely the reduction of gender dysphoria, which may or may not be present;
- Commit to harm reduction approaches where appropriate;
- Enable the full and ongoing informed participation of transgender and gender diverse people in decisions about their health and well-being;
- Improve experiences of health services, including those associated with administrative systems and continuity of care.

##### *Principles around working towards improved health through wider community approaches*

- Put people in touch with communities and peer support networks;
- Support and advocate for clients within their families and communities (schools, workplaces, and other settings) where appropriate.

We have already cited research detailing the broad range of challenges TGD people may face; social economic and legal obstacles, as well those related to health care access. While overall health care services are diverse across the world (in terms of availability, accessibility, and quality), those services available to TGD people are often inadequate. Numerous reports from diverse regions worldwide show, while TGD people may report positive health care experiences, many others do not (e.g., Callander et al., 2019; Costa, da Rosa Filho et al., 2018; Do et al., 2018; Gourab et al., 2019; Health Policy Project et al., 2015; Liu et al., 2020; Motmans et al., 2017; Muller et al., 2019; PAHO, 2014; Reisner et al., 2021; Strauss et al., 2017; TGEU, 2017). Mainstream health care options often do not meet their needs for general, sexual, or gender-affirming health care. Standard patient management procedures at clinics and hospitals often fail to recognize the gender identities of their TGD patients (including where outside of the binary their patients identify). Patients may be housed in wards that are gender inappropriate for them, putting them at risk of sexual harassment. TGD patients often encounter unsupportive or hostile attitudes from HCPs and ancillary staff and may even be refused service. Of great concern, HCPs in some parts of the world are involved in gender identity change efforts of the sort described earlier in this chapter.

Throughout the world, there are many other barriers to the provision of gender-affirming health care. Health care professionals may often be unwilling to provide the services TGD people seek. In some countries, there may be laws or regulations inhibiting or preventing them from doing so. When general practitioners and other health care providers do not have access to clear guidelines in their own language, they may be deterred from providing services. Even in situations where health care is available, patients may

find it is difficult to access because of distance, gatekeeping practices, supply and demand issues that result in long wait lists or cost increases. Indeed, gender-affirming procedures may not be incorporated into a universal health care provision or be covered by private insurance, even though similar procedures may be covered for cisgender patients.

For all these reasons, many TGD people avoid formal health care services whenever they can. Their own communities commonly fill the void, acting as important resources for their members. They provide social and emotional support, often in an otherwise hostile environment. In addition, they often act as reservoirs of shared information about available options for health care, including parallel and informal health care options outside of (and more accessible and affordable than) mainstream medicine. As we saw earlier in this chapter, this often includes sharing of information about silicone and other injectable substances for bodily transformation and about hormones that are self-administered without necessary medical monitoring or supervision. WHO notes TGD individuals who self-administer gender-affirming hormones would benefit from access to evidence-based information, quality products, and sterile injection equipment (WHO, 2021). Access to such information can form part of a broader harm reduction approach (e.g., Idrus & Hyman, 2014).

Putting the important core principles outlined above into practice can improve health care experiences and promote respect for TGD people in all local contexts. This can occur regardless of the realities of a health care system (including the cultural, social, legal, economic context in which health care is provided), the level of provision available, or the TGD people seeking such services.

### CHAPTER 3 Population Estimates

In the previous edition of its Standards of Care, Version 7, World Professional Association for Transgender Health (WPATH) identified only a small number of articles attempting to estimate the size of the transgender and gender diverse (TGD) population and characterized the state-of-the-science as “a starting point” requiring further systematic study (Coleman et al., 2012). Since then, the literature on this topic has expanded considerably as evidenced by a number of recent reviews that have sought to synthesize the available evidence (Arcelus et al., 2015; Collin et al., 2016; Goodman et al., 2019; Meier & Labuski, 2013; Zhang et al., 2020).

In reviewing epidemiologic data pertaining to the TGD population, it may be best to avoid the terms “incidence” and “prevalence.” Avoiding these and similar terms may preclude inappropriate pathologizing of TGD people (Adams et al., 2017; Bouman et al., 2017). Moreover, the term “incidence” may not be applicable in this situation because it assumes TGD status has an easily identifiable time of onset, a prerequisite for calculating incidence estimates (Celentano & Szklo, 2019). For all the above reasons, we recommend using the terms “number” and “proportion” to signify the absolute and the relative size of the TGD population.

Perhaps the most important consideration in reviewing this literature is the variable definition applied to the TGD population (Collin et al., 2016; Meier & Labuski, 2013). In clinic-based studies, the data on TGD people are typically limited to individuals who received transgender-related diagnoses or counseling or those who requested or underwent gender-affirming therapy, whereas survey-based research typically relies on a broader, more inclusive definition based on self-reported gender identities.

Another methodological consideration in assessing the size and distribution of the TGD population is the need to understand what constitutes the sampling frame. As noted in recent reviews (Goodman et al., 2019; Zhang et al., 2020), many of the published studies, especially those conducted more than a decade ago, first assessed the number of patients seen at a particular clinical center and then divided that number

by an approximated population size. This was unlikely to produce an accurate estimate because the numerator in the calculations is not necessarily included in the denominator, and the true size of the denominator often remains unknown.

With these considerations in mind, it is advisable to focus specifically on recent (published within the last decade) peer-reviewed studies that utilized sound methodology in identifying TGD people within a well-defined sampling frame. For all of the above reasons, the present chapter is focused on studies that met the following inclusion criteria 1) appeared in press in 2009 or later; 2) used a clear definition of TGD status; 3) calculated proportions of TGD people based on a well-defined population denominator; and 4) were peer-reviewed. These types of studies can provide more accurate contemporary estimates.

The available studies can be assigned into three groups 1) those that reported proportions of TGD people among individuals enrolled in large health care systems; 2) those that presented results from population surveys of predominantly adult participants; and 3) those that were based on surveys of youth conducted in schools. Of these three categories, the most informative and methodologically sound studies are summarized below. Additional details about these and other similar studies can be found in recent literature reviews (Goodman et al., 2019; Zhang et al., 2020).

Among studies that estimated the size of the TGD population enrolled in large health care systems, all were conducted in the US, and all relied on information obtained from electronic health records. Four of those health system-based studies relied exclusively on diagnostic codes to ascertain the TGD population; two studies (Blosnich et al., 2013; Kauth et al., 2014) used data from the Veterans Health Affairs system, which provides care to over 9 million people, and two studies (Dragon et al., 2017; Ewald et al., 2019) used claims data from Medicare, the federal health insurance program that primarily covers people 65 years of age or older. The proportions of TGD people reported in these diagnostic code-based studies ranged from approximately 0.02% to 0.03%. Another more recent publication also used Medicare data along with commercial insurance claims to identify TGD people and applied expanded inclusion criteria to supplement

diagnostic codes with information on procedures and hormone therapy (Jasuja et al., 2020). Using this methodology, the proportion of TGD people among all persons enrolled in the participating health plans was 0.03%. The sixth health systems-based study (Quinn et al., 2017) was conducted at Kaiser Permanente plans in the states of Georgia and California; these plans provide care to approximately 8 million members enrolled through employers, government programs, or individually. The TGD population in the Kaiser Permanente study was ascertained across all age groups using both diagnostic codes and free-text clinical notes. The proportions of TGD people identified at Kaiser Permanente were higher than the corresponding proportions reported in the Veterans Health Affairs and Medicare studies with the most recent estimates ranging from 0.04 to 0.08%.

In contrast to results from the health system-based studies, findings from surveys that relied on self-reported TGD status produced much higher estimates. Two US studies took advantage of the Behavioral Risk Factor Surveillance Study (BRFSS), which is an annual telephone survey conducted in all 50 states and US territories (Conron et al., 2012; Crissman et al., 2017). The first study used data from the 2007–2009 BRFSS cycles in the state of Massachusetts, and the second study used the 2014 BRFSS data from 19 states and the territory of Guam. Both studies reported that approximately 0.5% of adult participants (at least 18 years of age) responded “Yes” to the question “Do you consider yourself to be transgender?”

An internet-based survey administered to a sample of the Dutch population 15–70 years of age (Kuyper & Wijzen, 2014) asked participants to score the following two questions using a 5-point Likert scale: “Could you indicate to which degree you psychologically experience yourself as a man?” and “Could you indicate to which degree you psychologically experience yourself as a woman?” The respondents were considered “gender ambivalent” if they gave the same score to both statements and “gender incongruent” when they reported a lower score for their sex assigned at birth than for their gender identity. The proportions of participants reporting incongruent

and ambivalent gender identity were 1.1% and 4.6%, respectively, for persons who were assigned male at birth (AMAB), and 0.8% and 3.2%, respectively, for persons assigned female at birth (AFAB).

A similarly designed study estimated the proportion of TGD residents in the Flanders region of Belgium using a sample drawn from the country’s National Register (Van Caenegem, Wierckx et al., 2015). Participants were asked to score the following statements: “I feel like a woman” and “I feel like a man” on a 5-point Likert scale. Using the same definitions applied in the Dutch study (Kuyper & Wijzen, 2014), the proportion of gender incongruent individuals was 0.7% for AMAB people and 0.6% for AFAB people. The corresponding estimates for gender ambivalence among AMAB and AFAB people were 2.2% and 1.9%, respectively.

A more recent population-based study evaluated the proportion of TGD people among approximately 50,000 adult residents of Stockholm County, Sweden (Åhs et al., 2018). The numerator was determined by asking participants the following question: “I would like hormones or surgery to be more like someone of a different sex.” Two additional items were designed to identify individuals experiencing gender incongruence: “I feel like someone of a different sex” and “I would like to live as or be treated as someone of a different sex.” The need for either hormone therapy or gender-affirming surgery was reported by 0.5% of participants. Individuals who expressed feeling like someone of a different sex and those who wanted to live as or be treated as a person of another sex constituted 2.3% and 2.8% of the total sample, respectively.

Population-based data outside of North America and Western Europe are less common. One recent study offers valuable data from a large representative survey of 6,000 adults in Brazil (Spizzirri et al., 2021). Gender identity of participants was assessed based on the following three questions 1) “Which of the following options best describes how you currently feel?” (Options: I feel I am a man, I feel I am a woman, and I feel I am neither a man nor a woman); 2) “What is the sex on your birth certificate?” (Options: male, female, and undetermined); and 3) “Which of

*these situations do you most closely relate to?"* (Options: I was born male, but I have felt female since childhood; I was born female, but I have felt male since childhood; I was born male, and I feel comfortable with my body; I was born female, and I feel comfortable with my body). Based on the responses to these three questions, the authors determined 1.9% of the survey respondents were TGD (0.7% defined as transgender, and 1.2% defined as nonbinary).

The literature on the population proportions of TGD youth (persons under 19 years of age) includes several survey studies conducted in schools. A 2012 national cross-sectional survey in New Zealand collected information on TGD identity among high school students (Clark et al., 2014). Among over 8,000 survey participants, 1.2% self-identified as TGD and 2.5% reported they were not sure. Another study of schoolchildren was based on a 2016 survey of 9th and 11th grade students (ages 14–18 years) in the US state of Minnesota (Eisenberg et al., 2017). Of the nearly 81,000 survey respondents, 2.7% reported being TGD. A more recent study (Johns et al., 2019) presented results of the Youth Risk Behavior Survey (YRBS), which is conducted biennially among local, state, and nationally representative samples of US high school students in grades 9–12 (approximate age range 13–19 years). The 2017 YRBS cycle was carried out in 10 states and 9 large urban areas and included the following sequence: *"Some people describe themselves as transgender when their sex at birth does not match the way they think or feel about their gender. Are you transgender?"* Among nearly 120,000 participants across the 19 sites, 1.8% responded *"Yes, I am transgender,"* and 1.6% responded *"I am not sure if I am transgender."*

Another recently published school-based study in the US presented results of a 2015 survey conducted in Florida and California with the aim of identifying gender diverse children and adolescents in a sample of just over 6,000 students in grades 9–12 (Lowry et al., 2018). "High gender-nonconforming" was used to define AMAB children who reported being very/mostly/somewhat feminine or AFAB children who reported being very/mostly/somewhat masculine. Based on these definitions, the proportions of

TGD participants were reported to be 13% among AMAB students, 4% among AFAB students, and 8.4% overall.

Only one study examined the proportion of self-identified TGD children in a younger age group. Shields et al. analyzed the data from a 2011 survey of 2,700 students in grades 6–8 (age range 11–13 years) across 22 San Francisco public middle schools (Shields et al., 2013). Thirty-three children self-identified as TGD based on the question *"What is your gender?"* where the possible responses were *"female, male, or transgender."* The resulting proportion of transgender survey respondents was 1.3%. However, this definition would exclude TGD persons self-identifying as nonbinary and those who do not explicitly identify as transgender.

Taken together, these data indicate among health system-based studies that relied on diagnostic codes or other evidence documented in the medical records (Blosnich et al., 2013; Dragon et al., 2017; Ewald et al., 2019; Kauth et al., 2014; Quinn et al., 2017), the proportions of TGD people reported in recent years (2011–2016) ranged from 0.02% to 0.08%. By contrast, when the TGD status was ascertained based on self-report, the corresponding proportions were orders of magnitude higher and reasonably consistent, if the studies used similar definitions. When the surveys specifically inquired about "transgender" identity, the estimates ranged from 0.3% to 0.5% among adults and from 1.2% to 2.7% in children and adolescents. When the definition was expanded to include broader manifestations of gender diversity, such as gender incongruence or gender ambivalence, the corresponding proportions were higher: 0.5% to 4.5% among adults and 2.5% to 8.4% among children and adolescents.

As reviewed elsewhere (Goodman et al., 2019), another noteworthy observation is the continuous increase in both the size and the composition of the TGD population with upward trends in the proportion of TGD people observed in health care systems, through population-based surveys, as well as in the data on legal gender recognition. The higher estimates observed in more recent literature support some of the previous publications indicating the size of TGD population was

**Summary of reported proportions of TGD people in the general population**

Health systems-based studies: 0.02–0.1%

Survey-based studies of adults: 0.3–0.5% (transgender), 0.3–4.5% (all TGD)

Survey-based studies of children and adolescents: 1.2–2.7% (transgender), 2.5–8.4% (all TGD)

likely underestimated in earlier studies (Olyslager & Conway, 2008).

The temporal trends in AMAB to AFAB ratio have also been reported in studies analyzing referrals to clinics as well as data from integrated health systems; this ratio has changed from predominantly AMAB in previous decades to predominantly AFAB in recent years, especially among TGD youth (Aitken et al., 2015; de Graaf, Carmichael et al., 2018; de Graaf, Giovanardi et al. 2018; Steensma et al., 2018; Zhang et al., 2021). The trend towards a greater proportion of TGD people in younger age groups and the age-related differences in the AMAB to AFAB ratio likely represent the “cohort effect,” which reflects sociopolitical advances, changes in referral patterns, increased access to health care and to medical information, less pronounced cultural stigma, and other changes that have a differential impact across generations (Ashley 2019d; Pang et al., 2020; Zhang et al., 2020).

Despite recent improvements in the quality of published studies, an important limitation of the existing literature is the relative paucity of peer-reviewed publications from regions outside of Western Europe or North America. Some of the relevant information on global estimates can be obtained from reports supported by the governments or non-governmental organizations (Fisher et al., 2019; Kasianczuk & Trofymenko, 2020), but these reports may be difficult to systematically identify and evaluate until they appear in peer-reviewed literature. Other barriers to evaluating the global distribution of the TGD populations include inadequate access to demographic data and over-representation of English-language journals in the world literature.

These limitations notwithstanding, the available highest-quality data clearly indicate TGD people represent a sizable and growing proportion of the general population. Based on the credible evidence available to date, this proportion may range

from a fraction of a percent to several percentage points depending on the inclusion criteria, age group, and geographic location. Accurate estimates of the proportion, distribution, and composition of the TGD population as well as a projection of resources required to adequately support the health needs of TGD people should rely on systematically collected high-quality data, which are now increasingly available. Continuous and routine collection of these data is needed to decrease variability and minimize over- and under-estimation of the reported results. For example, far more accurate and precise estimates should become available when population censuses begin systematically collecting and reporting data on sex assigned at birth and gender identity, including asexual and nonbinary categories, using the now well-validated two-step method. The first such census-based estimate was released by the national statistical office of Canada. Based on the 2021 census data, 100,815 of 30.5 million Canadians self-identified as transgender or nonbinary; this accounted for 0.33% of the population 15 years of age or older (Statistics Canada, 2022). Consistent with the published literature, the proportions of transgender and nonbinary people were much higher for Generation Z (born between 1997 and 2006, 0.79%) and millennials (born between 1981 and 1996, 0.51%) than for Generation X (born between 1966 and 1980, 0.19%), baby boomers (born between 1946 and 1965, 0.15%), and the Interwar and Greatest Generations (born in 1945 or earlier, 0.12%). While these results represent the highest quality data available to date, it is not clear how the population proportions reported in Canada may compare with those in other countries. The variability in the definitions of what constitutes the TGD population and the differences in data collection methods can be reduced further by improving international collaborations.

## CHAPTER 4 Education

This chapter will provide a general review of the literature related to education in transgender and gender diverse (TGD) health care. Recommendations are offered at governmental, nongovernmental, institutional, and provider levels with the goal of increasing access to competent, compassionate health care. In turn, this increased access should improve health outcomes in TGD populations. As this is a novel chapter in the World Professional Association for Transgender Health (WPATH) Standards of Care, the intent is to lay the groundwork for the education area and invite a broader and deeper discussion among educators and health professionals.

Health professionals involved in transgender care encompass a broad range of disciplines. Health professional education varies considerably by country or region in terms of structure, licensure, and policy. Published literature on education in TGD health care is predominantly from North America, Europe, Australia and New Zealand. This chapter does not provide a review of the education literature for each discipline, the needs specific to each discipline (which can be found in the relevant chapters), or the needs specific to each country/region's health education system. Greater understanding and research are needed on the intersection of health education systems, licensure, and transgender health across the world.

On a global level, TGD health education is imperative if national and international health disparities are to be addressed. Cultural competency related to TGD communities continues to be lacking. The World Bank Group (2018) reports widespread discrimination, harassment, violence, and abuse affecting TGD people. They also report TGD people face the highest rates of violence and discrimination (World Bank Group, 2018). Although many higher income countries have national antidiscrimination laws with gender identity as a protected characteristic, discrimination in the workplace, in education, and in health care remains problematic (World Bank Group, 2018).

Across disciplines, curricula at all levels—undergraduate, graduate, residency, or continuing education—historically have ignored TGD cultural or clinical education. The Joint Commission (US) has recommended health care organizations “provide educational programs and forums that support the unique needs of the LGBT community” and “offer educational opportunities that address LGBT health issues” (The Joint Commission, 2011). However, this is not enforced.

On an individual level, several questions need answers. What type of education interventions can most effectively address transphobia and lead to long-standing changes in attitudes? What interventions translate into increasing the number of care providers in this area as well as the number of TGD people receiving care? Does clinical exposure increase the confidence of providers over time? What educational interventions lead to improved health outcomes in the TGD population and, if so, when and how did these interventions accomplish this? Although health professions have begun to incorporate TGD health into education using a variety of modalities and at varying levels of training, efforts differ by health profession and are neither systemic nor systematic in nature (e.g., Brennan et al., 2012; Chinn, 2013; Eliason et al., 2010; Lim et al., 2015; Obedin-Maliver et al., 2011; Rondahl, 2009).

Attaining cultural humility with the full appreciation of the intersectionality of humanity is an ultimate educational goal. That said, this initial call for education is focused on building the foundation in cultural awareness and cultural competency that is currently weak or non-existent in much of the world.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

**Statements of Recommendations**

- 4.1- We recommend all personnel working in governmental, nongovernmental, and private agencies receive cultural-awareness training focused on treating transgender and gender diverse individuals with dignity and respect.
- 4.2- We recommend all members of the health care workforce receive cultural-awareness training focused on treating transgender and gender diverse individuals with dignity during orientation and as part of annual or continuing education.
- 4.3- We recommend institutions involved in the training of health professionals develop competencies and learning objectives for transgender and gender diverse health within each of the competency areas for their specialty.

Recommendation 4.1

**We recommend all personnel working in governmental, nongovernmental, and private agencies receive cultural-knowledge training focused on treating transgender and gender diverse individuals with dignity and respect.**

Article 1 of the United Nations Universal Declaration of Human Rights states, “All human beings are born free and equal in dignity and rights” (United Nations, 1948). Only recently has this fundamental statement included the recognition that TGD rights are human rights (UNOCHR, 2018). Globally, training at all levels about TGD communities continues to be lacking. As recently as 2002, only 3% of Fortune 500 companies had antidiscrimination protection for TGD employees, and none offered insurance coverage for gender-affirming health care (Human Rights Campaign Foundation, 2017). By 2022, 91% of Fortune 500 companies included gender identity in US non-discrimination policies, and 66% offered TGD-inclusive insurance coverage. However, only 72% provide any form of lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) cultural knowledge training for their workforce (Human Rights Campaign Foundation, 2022). This lack of understanding fosters discrimination across the board. Taken together, these inconsistencies negatively affect the health of individuals and communities and exacerbate the health disparities and inequities they face. In Britain, only 28% of TGD workers felt the senior leadership were committed to TGD equality; only 21% of TGD employees would consider reporting transphobic harassment in the workplace (Stonewall, 2018). For those who are openly TGD, 34% were excluded by their co-workers, 35% were abused by customers, 24% were denied promotion due to their gender identity, and 11% were fired (Stonewall, 2018). In southeastern Europe, the World Bank stated there is widespread discrimination, harassment, violence,

and abuse, and TGD people in that region faced the highest rates of violence and discrimination (World Bank Group, 2018). Often the discrimination went unreported with 60% of individuals not filing a report because of a lack of faith the complaint would be addressed, a fear of further discrimination or ridicule, and a reluctance to be outed (World Bank Group, 2018). Although many countries in the region have national antidiscrimination laws with gender identity as a protected characteristic, discrimination in the workplace, in education, and in health care remains problematic (World Bank Group, 2018). It is the responsibility of the governmental, nongovernmental, and private agencies in these countries with anti-discrimination laws to ensure the rights of the TGD population. They are, therefore, obligated to find ways in which discrimination and stigma can be decreased. One of these is through education. Local cultures that foster anti-TGD attitudes are often a barrier to this needed education. Although cultural competency trainings have led to equivocal results, Shepherd (2019) recommends that providing cultural knowledge training that prioritizes local cultural issues and focuses on the values of openness, non-judgment, and responsiveness may lead to the desired results. Implementing cultural knowledge training requires a leadership willing to prioritize the training and to dedicate the time, money, and human capital to delivering initial and ongoing training.

Recommendation 4.2

**We recommend all members of the health care workforce receive cultural-knowledge training focused on treating transgender and gender diverse individuals with dignity during orientation and as part of annual or continuing education.**

Across disciplines, curricula at all levels—undergraduate, graduate, residency, or continuing

education—historically have ignored TGD cultural or clinical education. Factors contributing to this lack of inclusion include lack of faculty knowledge, experience, comfort with the subject matter, faculty bias, limited space within the existing curriculum, and lack of guidance on how to integrate the topics (McDowell & Bower, 2016). Research into the lack of and the need for such education does not specifically address TGD health concerns. Rather, the existing literature subsumes TGD health education within the broader discussion of the lack of LGBTQ-focused cultural and clinical-competency training. As an example, nursing baccalaureate programs included only an average of 2.12 hours of instruction on LGBTQ health (Lim et al., 2015). A fair assumption is that the amount of time devoted to TGD-specific health issues constituted only a fraction of this time.

Within the broader context of LGBTQ competency, the lack of TGD cultural- and clinical-competency training is a long-known shortfall of health care education (Aldridge et al., 2021). In the US, the Department of Health and Human Services' *Healthy People 2020*, (United States Department of Health and Human Services (2013, April 10)), the National Academy of Medicine (The Institute of Medicine, 2011), and the Joint Commission (The Joint Commission, 2011) all recognized lack of education negatively impacts the ability of LGBTQ people, including TGD individuals, to obtain appropriate, medically necessary care. The UK's House of Commons Women and Equalities Committee found lack of education contributed to TGD health disparities in the National Health Service (House of Commons Women and Equalities Committee, 2015, December 8). The lack of TGD health care education has been identified in the US (Obedin-Maliver et al., 2011), UK (Tollemache et al., 2021), South Africa (de Vries et al., 2020; Taylor et al., 2018; Wilson et al., 2014), Canada (Bauer et al., 2014), Australia (Riggs & Bartholomaeus, 2016), Sweden, Spain, Serbia, Poland (Burgwal et al., 2021), and Pakistan (Martins et al., 2020) among other countries.

In addition to developing curriculum, Shepherd (2022) states both clinical and organizational components are necessary to improve clinical

encounters and consumer satisfaction. On an organizational level, it must be feasible as well as locally and practically oriented (Shepherd, 2022). On an individual level, in addition to knowledge training, health care professionals are better served employing generic traits that focus on the values of openness, non-judgment, and responsiveness (Shepherd, 2018).

#### Recommendation 4.3.

**We recommend institutions involved in the training of health professionals develop competencies and learning objectives for transgender and gender diverse health within each of the competency areas for their specialty.**

Each health profession has its own educational institutions, administrative, and licensing bodies, which vary by country and specialization within the profession. No major health professional organizations, educational institutions, or licensing bodies appear to require training in TGD health. While these organizations increasingly recommend including LGBTQ intersex health, rarely do they specify competencies, skills, or learning objectives for working with TGD people within their specialty. Published material on health professional education in TGD health is focused primarily on nursing, medicine, and mental health and is predominantly from North America, Europe, Australia, and New Zealand. An increased understanding of transgender health and medical/health professional education systems and requirements globally is essential.

Despite the increasing visibility of TGD people, access to knowledgeable and culturally-competent health professionals remain an overwhelming need around the world (James et al., 2016; Lerner et al., 2020; Müller, 2017). Lack of knowledgeable providers is a major barrier to gender-affirming care for transgender persons (Puckett et al., 2018; Safer et al., 2016) and contributes to large health disparities (Giffort & Underman, 2016; Reisman et al., 2019). The lack of adequate professional education in TGD health is a global problem (Do & Nguyen, 2020; Martins et al., 2020; Parameshwaran et al., 2017) that occurs at all levels of training (Dubin et al., 2018) and traverses health disciplines (Glick et al., 2020; Gunjawate et al., 2020; Johnson & Federman,

2014) and medical specialties (Fung et al., 2020; Korpaisarn and Safer, 2018).

Challenges remain as studies to date have small sample sizes, involve one-time training, include multiple disciplines at multiple career levels, focus on short-term outcomes, and often cover all LGBTQI topics rather than TGD-specific ones that are usually acquired post-licensure and are not the focus of most currently studied educational interventions (Dubin et al., 2018).

To successfully implement the recommendations, institutions may need to consider

developing 1) systemic and systematic approaches to developing and implementing competencies for each health discipline across the professional lifespan; 2) standardized assessments for learners, with input from the TGD community; and 3) allotment of curricular resources, including trained faculty, as well as time in accordance with clear, consensual learning objectives (Dubin et al., 2018; Pratt-Chapman, 2020). In addition, evaluations of these interventions should not only focus on outcomes but also strive to understand how, when, and why these outcomes are occurring (Allen et al., 2021).

## CHAPTER 5 Assessment of Adults

This chapter provides guidance for the assessment of transgender and gender diverse (TGD) adults who are requesting medically necessary gender-affirming medical and/or surgical treatments (GAMSTs) to better align their body with their gender identity (see medically necessary statement in Chapter 2—Global Applicability, Statement 2.1).

TGD adults are people at or above the age of majority in their country, who have some form of gender diversity. The developmental elements of the adolescent chapter, including the importance of parental/caregiver involvement, may be relevant for the care of young adults too, even if they are above the age of majority.

This chapter includes all forms of gender identities and transitions including, but not limited to, male, female, gender diverse, nonbinary, agender, and eunuch. The population of TGD adults is heterogeneous and will vary according to their clinical need, biological, psychological, and social situations, as well as their access to health care. As such, any assessment for GAMSTs will need to be adapted to the scientific, clinical, and community knowledge base of the presenting gender identity as well as local circumstances. This chapter recognizes individuals may experience different local levels of clinical or regulatory oversight when the state or others are providing health care.

An individual's gender identity is an internal identification and experience. The role of the assessor is to assess for the presence of gender incongruence and identify any co-existing mental health concerns, to offer information about GAMSTs, to support the TGD person in considering the effects/risks of GAMSTs, and to assess if the TGD person has the capacity to understand the treatment being offered and if the treatment is likely to be of benefit. The assessor can also assist a TGD person to consider choices that could improve their GAMST outcomes. The GAMST assessment approach described in this chapter recognizes the lived experience and self-knowledge of the TGD person and the clinical knowledge of the assessing health care professional (HCP). Consequently, with this approach, the decision to move forward with GAMSTs is shared between the TGD person and the

assessing HCP, with both playing a key part in collaborative decision-making.

Some systems use a model of care for TGD adults seeking GAMSTs that prioritizes the TGD adult as the decision maker with the HCP acting as an advisor, barring serious contraindications. These models are used when considering hormone therapy rather than surgery and are often called “informed consent” models (Deutsch, 2011, 2016a). Many such models utilize an abbreviated assessment that focuses primarily on the ability of a TGD person to grant informed consent and to utilize information about GAMSTs to inform their medical decision-making. There is significant variability in such models across jurisdictions, systems, and HCPs (Deutsch, 2011; Morenz et al., 2020). Informed consent models have been used for some time for hormone prescription in many local settings.

This chapter is intended to offer flexible global guidance that must be adapted to local circumstances. HCPs will need to determine which assessment approaches best meet the needs in their local settings. The evaluation of these approaches is best undertaken in collaboration with TGD people.

Since TGD people represent a diverse array of gender identities and expressions and have differing needs for GAMSTs, no single assessment process will fit every person or every situation. Some TGD people may need a comparatively brief assessment process for GAMSTs. For TGD adults with a complex presentation or for those who are requesting less common treatments or treatments with limited research evidence, more comprehensive assessments with different members of a multidisciplinary team will be required. Assessments may be in person or through telehealth. While psychometric assessment tools have been used in some instances, they are not a required part of the assessment for GAMSTs. Counseling or psychotherapy can be helpful when requested by a TGD person. However, counseling or psychotherapy specifically focused on their TGD identity is not a requirement for the assessment or initiation of GAMSTs. Genital exams are not a prerequisite for initiation of GAMSTs and should be performed only when clinically indicated.

GAMSTs can be delivered in diverse settings. Settings will depend on available health care systems within each country and may include nationalized/public health care, private sector settings, community health care settings, and charitable institutions. Local and regional circumstances may therefore influence the availability of health care. Regardless of the setting, health care offered to TGD people should be of the highest possible quality. World Professional Organization for Transgender Health (WPATH) advocates for assessment and treatment to be readily available. Access to assessment and treatment for TGD

people seeking GAMSTs is critical given the clear medical necessity of these interventions and the profound benefits they offer to TGD people (Aldridge et al., 2020; Byne et al., 2012). The guidance in this chapter will need to be adapted according to local, as well as individual, clinical, and social circumstances.

The statements below are based on significant background literature, including literature demonstrating the strong positive impact of access to GAMSTs; available empirical evidence; a favorable risk-benefit ratio; and consensus of professional best practice. The empirical evidence base for the

### **Statements of Recommendations**

- 5.1- We recommend health care professionals assessing transgender and gender diverse adults for physical treatments:
- 5.1.a- Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.
  - 5.1.b- For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.
  - 5.1.c- Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.
  - 5.1.d- Are able to assess capacity to consent for treatment.
  - 5.1.e- Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity.
  - 5.1.f- Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.
- 5.2- We suggest health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required.

*The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (all should be met):*

- 5.3- We recommend health care professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:
- 5.3.a- Only recommend gender-affirming medical treatment requested by a TGD person when the experience of gender incongruence is marked and sustained.
  - 5.3.b- Ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care.
  - 5.3.c- Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.
  - 5.3.d- Ensure that any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
  - 5.3.e- Ensure any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.
  - 5.3.f- Assess the capacity to consent for the specific physical treatment prior to the initiation of this treatment.
  - 5.3.g- Assess the capacity of the gender diverse and transgender adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.
- 5.4- We suggest, as part of the assessment for gender-affirming hormonal or surgical treatment, professionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider the role of social transition together with the individual.
- 5.5- We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.
- 5.6- We suggest health care professionals assessing transgender and gender diverse people seeking gonadectomy consider a minimum of 6 months of hormone therapy as appropriate to the TGD person's gender goals before the TGD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).
- 5.7- We recommend health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professional in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.

assessment of TGD adults is limited. It primarily includes an assessment approach that uses specific criteria that are examined by an HCP in close cooperation with a TGD adult and does not include randomized controlled trials or long-term longitudinal research (Olsen-Kennedy et al., 2016). This is understandable given the complexity and ethical considerations of allocating patients in need of care to different assessment groups and the lack of funding for research and other resources to assess long-term outcomes of assessment approaches.

The creation of this guidance has been a complex undertaking. The criteria in this chapter have been significantly revised from SOC-7 to reduce requirements and unnecessary barriers to care. It is hoped that future research will explore the effectiveness of this model as well as evolving assessment models for hormone therapy and for surgery that will allow continued improvements to be made.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

#### Statement 5.1.

**We recommend health care professional assessing transgender and gender diverse adults for gender-affirming treatments:**

##### Statement 5.1.a

**Are licensed by their statutory body and hold, at a minimum, a master's degree or equivalent training in a clinical field relevant to this role and granted by a nationally accredited statutory institution.**

TGD people, as with all other people seeking health care, should have the highest quality of care accessible that is commensurate with the quality of care provided to all people utilizing health services (The Yogyakarta Principles, 2017). As this will vary around the globe, the nature of the professional completing an assessment for GAMSTs will vary according to the nature of health care in the local setting as well as the regulatory requirements set by licensing and registration boards. It

is important the health care provided includes an assessment conducted by a competent, statutorily regulated HCP who has the competence to identify gender incongruence and conditions that can be mistaken for gender incongruence and who can support the TGD person throughout the assessment process (RCGP, 2019). Assessors must be able to refer to HCPs licensed to provide GAMSTs.

HCPs should have at a minimum a masters-level qualification in a clinical field related to transgender health or equivalent further clinical training and be statutorily regulated; examples include a mental health professional (MHP), general medical practitioner, nurse, or other qualified HCP. In some settings, statutorily regulated HCPs with lower levels of qualification may practice under the clinical supervision of a qualified HCP who takes ultimate clinical responsibility for the quality and accuracy of the completed GAMST assessment. For additional information see Chapter 4—Education.

Accessing a competent, statutorily regulated, HCP with expertise in GAMST assessment can sometimes be difficult. Consequently, ensuring continuity of care and minimizing gaps in accessible care or significantly delayed care (e.g., a long waiting list) may require that a statutorily regulated HCP without expertise provide care and support the assessment of a TGD person for GAMSTs. Avoiding unnecessary delays in care is critically important. However, TGD people should be supported to access care with an experienced HCP as soon as possible (RCGP, 2019).

Established practice requires the competence to identify and diagnose gender incongruence (Hembree et al., 2017; Reed et al., 2016; T'Sjoen et al., 2020) and the ability to identify differentials or conditions that may be mistaken as gender incongruence (Byne et al., 2018; Dhejne et al., 2016; Hembree et al., 2017). Established practice also strongly emphasizes the need for ongoing continuing education in the assessment and provision of care of TGD people (American Psychological Association, 2015; T'Sjoen et al., 2020). For more information see Chapter 4—Education.

##### Statement 5.1.b

**For countries requiring a diagnosis for access to care, the health care professional should be competent using the latest edition of the World Health**

**Organization's International Classification of Diseases (ICD) for diagnosis. In countries that have not implemented the latest ICD, other taxonomies may be used; efforts should be undertaken to utilize the latest ICD as soon as practicable.**

In some countries, a diagnosis of gender incongruence may be necessary to access GAMSTs (as described below). HCPs assessing TGD people in those countries should be competent to diagnose gender incongruence using the most current classification system necessary for TGD people to access GAMSTs. The ICD-11 (WHO, 2019a) is a classification system that focuses on the TGD person's experienced identity and any need for GAMSTs and does not consider a TGD identity to be a mental illness.

Statement 5.1.c

**Are able to identify co-existing mental health or other psychosocial concerns and distinguish these from gender dysphoria, incongruence, and diversity.**

Gender diversity is a natural variation in people and is not inherently pathological (American Psychological Association, 2015). However, assessment is best provided by an HCP who possesses some expertise in mental health in order to identify conditions that can be mistaken for gender incongruence. Such conditions are rare and, when present, are often psychological in nature (Byne et al., 2012; Byne et al., 2018; Hembree et al., 2017).

The need to include an HCP with some expertise in mental health does not require the inclusion of a psychologist, psychiatrist, or social worker in each assessment. Instead, a general medical practitioner, nurse, or other qualified HCP could also fulfill this requirement if they have sufficient expertise to identify gender incongruence, recognize mental health concerns, distinguish between these concerns and gender dysphoria, incongruence, and diversity, assist a TGD person in care planning and preparation for GAMSTs, and refer to a mental health professional (MHP), if needed. As discussed in greater depth in the mental health chapter, MHPs have an important role to play in the care of TGD people. For example, the prejudice and discrimination experienced by some TGD people (Robles et al., 2016) can lead to depression, anxiety, or worsening of other mental health conditions. In such cases, an

MHP can diagnose, clarify, and treat mental health conditions. MHPs and HCPs with expertise in mental health are well-placed to assess for GAMSTs, as well as to support TGD people who require or request mental health input or support during their transition. For additional information see Chapter 18—Mental Health.

Statement 5.1.d

**Are able to assess capacity to consent for treatment.**

An assessment for GAMSTs must include an examination of the TGD person's ability to consent to the proposed treatment. Consent requires the cognitive capacity to understand the risks and benefits of a treatment and the potential negative and positive outcomes. It also requires the ability to retain that information for the purposes of making the decision (using aids as necessary) as well as the cognitive ability to use that understanding to make an informed decision (American Medical Association, 2021; Applebaum, 2007).

Some TGD individuals will have the capacity to grant consent immediately during the assessment. Some TGD individuals may need a longer process to be able to consent through ongoing discussion and the practice of medical decision-making skills. The presence of psychiatric illness or mental health symptoms do not pose a barrier to GAMSTs unless the psychiatric illness or mental health symptoms affect the TGD person's capacity to consent to the specific treatment being requested or affect their ability to receive treatment. This is especially important because GAMSTs have been found to reduce mental health symptomatology for TGD people (Aldridge et al., 2020).

Health care systems can consider GAMSTs for individuals who may not be able to directly consent if an appropriate legal guardian or regulator-approved independent decision maker with the power to determine health care treatment grants consent and confirms the proposed treatment is in alignment with the TGD individual's needs and wishes.

Statement 5.1.e

**Have experience or be qualified to assess clinical aspects of gender dysphoria, incongruence, and diversity. For supporting text, see Statement 5.1.f.**

Statement 5.1.f

**Undergo continuing education in health care relating to gender dysphoria, incongruence, and diversity.**

As in any other area of clinical practice, it is vital HCPs who are providing assessment for the initiation of GAMSTs are knowledgeable and experienced in the health care of TGD people. If this is not possible in the local context, the HCP providing the assessment should work closely with an HCP who is knowledgeable and experienced. As part of their clinical practice, HCPs should commit to ongoing training in TGD health care, become a member of relevant professional bodies, attend relevant professional meetings, workshops or seminars, consult with an HCP with relevant experience, and/or engage with the TGD community. This is particularly important in TGD health care as it is a relatively new field, and the knowledge and terminology are constantly changing (American Psychological Association, 2015; Thorne, Yip et al., 2019). Consequently, keeping up to date in the areas of TGD health is vital for anyone involved in an assessment for GAMSTs.

Statement 5.2

**We suggest health care professionals assessing transgender and gender diverse adults seeking gender-affirming treatment liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required.**

If required and if possible, assessment for GAMST should be conducted by a multidisciplinary team (Costa, Rosa-e-Silva et al., 2018; Hembree et al., 2017; Karasic & Fraser, 2018; T'Sjoen et al., 2020) with team members who have timely and adequate contact with one another. This could include an MHP, an endocrinologist, a primary care provider, a surgeon, a voice and communication specialist, TGD peer navigator, and others. In some cases, a multidisciplinary team may not be required; however, should a multidisciplinary team be needed, it is critical HCPs be able to access colleagues from different disciplines in a timely manner to complete the GAMST assessment and best support the needs of the TGD person. It is also critical TGD people be supported with follow-up appointments with any HCP who was involved during the assessment for GAMSTs, prior to,

during, and after the initiation of gender-affirming treatments.

**The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (all should be met):**

Statement 5.3

**We recommend health care professionals assessing transgender and gender diverse adults for gender-affirming medical and surgical treatment:**

Statement 5.3.a

**Only recommend gender-affirming medical treatment requested by a TGD person when the experience of gender incongruence is marked and sustained.**

To access GAMSTs, a TGD person's gender incongruence must be marked and sustained. This can include a need for GAMSTs and a desire to be accepted as a person of the experienced gender. Consequently, a consideration of the nature, length and consistency of gender incongruence is important. This can include such factors as a change of name and identity documents, telling others about one's gender, health care documentation, or changes in gender expression. However, marked and sustained gender incongruence can exist in the absence of disclosure to others by the TGD person (Brumbaugh-Johnson & Hull, 2019; Saeed et al., 2018; Sequeira et al., 2020). An abrupt or superficial change in gender identity or lack of persistence is insufficient to initiate gender-affirming treatments, and further assessment is recommended. In such circumstances, ongoing assessment is helpful to ensure the consistency and persistence of gender incongruence before GAMSTs are initiated.

While marked and sustained gender incongruence should be present, it is not necessary for TGD people to experience severe levels of distress regarding their gender identity to access gender-affirming treatments. In fact, access to gender-affirming treatment can act as a prophylactic measure to prevent distress (Becker et al., 2018; Giovanardi et al., 2021; Nieder et al., 2021; Nobili et al., 2018; Robles et al., 2016). A TGD adult can have sustained gender incongruence without significant distress and still benefit from GAMSTs.

Established clinical practice examines the persistence of gender incongruence when considering the initiation of GAMSTs (Chen & Loshak, 2020). In a review of 200 clinical notes, Jones, Brewin et al. (2017) identified the importance of the “stability of gender identity” when planning care. Providing GAMSTs to TGD people with persistent gender incongruence has been associated with low rates of patient regret and high rates of patient satisfaction (Becker et al., 2018; El-Hadi et al., 2018; Staples et al., 2020; Wiepjes et al., 2018). However, while the ICD 11 (WHO, 2019a) requires the presence of marked and persistent gender incongruence for a diagnosis of gender incongruence to be made, there is little specific evidence concerning the length of persistence required for treatment in adults. HCPs involved in an assessment of a TGD person for GAMSTs are encouraged to give due consideration to the life stage, history, and current circumstances of the adult being assessed.

#### Statement 5.3.b

##### **Ensure fulfillment of diagnostic criteria prior to initiating gender-affirming treatments in regions where a diagnosis is necessary to access health care.**

A diagnosis of gender incongruence may be necessary in some regions to access transition-related care. When a diagnosis is necessary to access GAMSTs, the assessment for GAMSTs will involve determining and assigning a diagnosis. In these instances, HCPs should have competence using the latest International Classification of Diseases and Related Health Problems (ICD) (WHO, 2019a). In regions where a diagnosis is necessary to access health care, a diagnosis of *HA60 Gender Incongruence of Adolescence or Adulthood* should be determined prior to gender-affirming interventions. Gender-affirming interventions secondary to a diagnosis of *HA6Z Gender Incongruence, Unspecified* may be considered in the context of a more comprehensive assessment by the multidisciplinary team.

There is evidence the use of rigid assessment tools for “transition readiness” may reduce access to care and are not always in the best interest of the TGD person (MacKinnon et al., 2020). Therefore, in situations where the assignment of a diagnosis is mandatory to access care, the process should be approached with trust and

transparency between the HCP and the TGD individual requesting GAMST, with the needs of the TGD individual in mind. Indeed, high quality relationships between TGD people and their HCPs are associated with lower emotional distress and better outcomes (Kattari et al., 2016). Because many TGD people fear HCPs will erroneously conflate transgender identity with mental illness (Ellis et al., 2015), a diagnostic assessment should be undertaken with sensitivity to facilitate the best relationship between the provider and the TGD individual.

#### Statement 5.3.c

##### **Identify and exclude other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments.**

In rare cases, TGD individuals might have a condition that may be mistaken for gender incongruence or may have another reason for seeking treatment aside from the alleviation of gender incongruence. In these cases, and when there is ambiguity regarding the diagnosis of gender incongruence, a more detailed and comprehensive assessment is important. For example, further assessment might be required to determine if gender incongruence persists outside of an acute psychotic episode. If gender incongruence persists after an acute psychotic episode resolves, GAMSTs may be considered as long as the TGD person has the capacity to consent to and undergo the specific treatment. If gender incongruence does not persist and only occurs during such an episode, treatment should not be considered. It is important such circumstances be identified and excluded prior to the initiation of GAMSTs (Byne et al., 2012, 2018; Hembree et al., 2017). It is important to understand, however, TGD people may present with gender incongruence and with a mental health condition, autistic spectrum disorder, or other neurodiversity (Glidden et al., 2016). Indeed, some mental health conditions, such as anxiety (Bouman et al., 2017), depression (Heylens, Elaut et al., 2014; Witcomb et al., 2018), and self-harm (Arcelus et al., 2016; Claes et al., 2015) are more prevalent in TGD people who have not accessed GAMSTs. Recent longitudinal studies suggest mental health symptoms experienced by TGD people tend to improve following GAMSTs (Aldridge et al., 2020; Heylens, Verroken et al., 2014;

White Hughto & Reisner, 2016). There is no evidence to suggest a benefit of withholding GAMSTs from TGD people who have gender incongruence simply on the basis that they have a mental health or neurodevelopmental condition. For more information see Chapter 18—Mental Health.

Statement 5.3.d

**Ensure any mental health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.**

Like their cisgender counterparts, TGD people may have mental health problems. Treatment for mental health problems can and should occur in conjunction with GAMSTs when medical transition is needed. It is vital gender-affirming care is not impeded unless, in some extremely rare cases, there is robust evidence that doing so is necessary to prevent significant decompensation with a risk of harm to self or others. In those cases, it is also important to consider the risks delaying GAMSTs poses to a TGD person's mental and physical health (Byne et al., 2018).

In general, social and medical transition of TGD people are both associated with a reduction in mental health problems (Aldridge et al., 2020; Bouman et al., 2017; Durwood et al., 2017; Glynn et al., 2016; Hughto & Reisner, 2016; Wilson et al., 2015; Witcomb et al., 2018). Unfortunately, the loss of social support and the physical and financial stress that can be associated with the initiation of GAMSTs may exacerbate pre-existing mental health problems and warrant additional support from the treating HCP (Budge et al., 2013; Yang, Wang et al., 2016). An assessment of mental health symptoms can improve transition outcomes, particularly when the assessment is used to facilitate access to psychological and social support during transition (Byne et al., 2012). A delay of transition in rare circumstances may be considered if, for example, the TGD person is unable to engage with the process of transition or would be unable to manage aftercare following surgery, even with support. Where a delay in GAMST as a last resort has been found to be necessary,

the HCP should offer resources and support to improve mental health and facilitate re-engagement with the GAMST process as soon as practicable. It should be noted access to medical transition for TGD people facilitates social transition and improves safety in public (Rood et al., 2017). In turn, the degree to which TGD people's appearance conforms to their gender identity is the best predictor of quality of life and mental health outcomes following medical transition (Austin & Goodman, 2017). Delaying access to GAMSTs due to the presence of mental health problems may exacerbate symptoms (Owen-Smith et al., 2018) and damage rapport; consequently, this should be done only when all other avenues have been exhausted.

Statement 5.3.e

**Ensure any physical health conditions that could negatively impact the outcome of gender-affirming medical treatments are assessed, with risks and benefits discussed, before a decision is made regarding treatment.**

In rare cases, GAMSTs, such as hormonal and surgical interventions, may have iatrogenic consequences or may exacerbate pre-existing physical health conditions (Hembree et al., 2017). In these instances, care should be taken, whenever possible, to manage pre-existing physical health conditions while initiating (if appropriate) or continuing gender-affirming treatments. Any interruptions in treatment should be as brief as possible and with treatment re-initiated as soon as practicable. Limited data and inconsistent findings suggest an association between cardiovascular and metabolic risks and hormone therapy in TGD adults (Getahun, 2018; Iwamoto, Defreyne et al., 2019; Iwamoto et al., 2021; Spanos et al., 2020). Because of the possible harm related to long-term treatment and the probable benefits expected from the preventive measures applied before and during hormone treatment, a careful assessment of physical health conditions prior to initiation of treatment is important. Some specific conditions, such as a history of hormone-sensitive cancer, may require further assessment and management that may preclude hormone treatment (Center of Excellence for Transgender Health, 2016; Hembree et al., 2017).

Similar concerns may be present for TGD adults who wish to access surgical interventions. Each gender-affirming surgical intervention has specific risks and potentially unfavorable consequences (Bryson & Honig, 2019; Nassiri et al., 2020; Remington et al., 2018). However, intervention-specific risks associated with the presence of specific physical conditions have not been well researched. Thus, the kinds of medical concerns raised by TGD people during the assessment are typically no different from those of any other surgical candidate.

Taking into consideration the mental and physical health disparities (Brown & Jones, 2016) and barriers to health care (Safer et al., 2016) experienced by TGD people, the assessment of physical conditions by HCPs should not be limited to a history of medical interventions. If the TGD person has physical health conditions, it is important these conditions are managed while initiating or continuing GAMSTs whenever possible. Any interruption in treatment should be made with a view toward re-initiating treatment as soon as practicable. It is also important HCPs develop a treatment strategy for managing physical conditions that facilitates health and promotes consistent adherence to a treatment plan.

#### Statement 5.3.f

#### **Assess the capacity to consent for the specific gender-affirming treatments prior to the initiation of this treatment.**

The practice of informed consent to treatment is central to the provision of health care. Informed consent is couched in the ethical principle that recipients of health care should understand the health care they receive and any potential consequences that could result. The importance of informed consent is embedded in many legislative and regulatory practices that guide HCPs around the world (Jefford & Moore, 2008). It is not possible to know all the potential consequences of a health care treatment; instead, considering what would be “reasonable” to expect is often used as a minimum criterion for consent (Jefford & Moore, 2008; Spatz et al., 2016) and remains the case with GAMSTs. Being able to consent to a health care procedure or clinical intervention requires several complex cognitive processes.

Consent requires the cognitive capacity to understand the risks and benefits of a treatment and the potential negative and positive outcomes in addition to the ability to retain that information for the purposes of making the decision (using aids as necessary) and the cognitive ability to use that understanding to make an informed decision (American Medical Association, 2021; Applebaum, 2007). It is vital the TGD person and the assessing HCP consider a priori the nature of the treatment sought and the potential positive and negative effects it may have on the biological, psychological, and social domains of the TGD person’s life.

It is important to recognize mental illness, in particular symptoms of cognitive impairment or psychosis, can impact a person’s ability to grant consent for GAMSTs (Hostiuc et al., 2018). However, the presence of such symptoms does not necessarily equate to an inability to give consent because many people with significant mental health symptoms are able to understand the risks and benefits of treatment enough to make an informed decision (Carpenter et al., 2000). Instead, it is important a careful assessment is carried out that examines each TGD person’s ability to comprehend the nature of the specific GAMST being considered, consider treatment options, including risks and benefits, appreciate the potential short- and long-term consequences of the decision, and communicate their choice in order to receive the treatment (Grootens-Wiegers et al., 2017).

There may be instances in which an individual lacks the capacity to consent to health care, such as during an acute episode of psychosis or in situations where an individual has long-term cognitive impairment. However, limits to capacity to consent to treatment should not prevent individuals from receiving appropriate GAMSTs. For some, understanding the risks and benefits may require the use of repeated explanations in jargon-free language over time or the use of diagrams to facilitate explanation and aid comprehension. A comprehensive and thorough assessment undertaken by the multidisciplinary health care team can further inform this process. For others, an alternative decision maker, such as a legal guardian or regulator-approved,

independent decision maker may need to be appointed. These situations need to be considered on a case-by-case basis with the aim of ensuring the most affirmative and least restrictive health care is provided to the individual. Also see Chapter 11—Institutional Environments.

#### Statement 5.3.g

**Assess the capacity of the gender diverse and transgender adult to understand the effect of gender-affirming treatment on reproduction and explore reproductive options with the individual prior to the initiation of gender-affirming treatment.**

As gender-affirming medical interventions often affect reproductive capacity, HCPs should ensure a TGD person is aware of the implications for reproduction of the treatments and is familiar with gamete storage and assistive reproductive options. Gender-affirming hormone treatments have been shown to impact reproductive functions and fertility, although the consequences are heterogenous for people of all birth-assigned sexes (Adeleye et al., 2019; Jindarak et al., 2018; Taub et al., 2020). There may be individual differences and fluctuations in these effects on TGD adults. It is therefore essential that HCPs inform a TGD person about the possible impact of the treatment on their reproductive potential during the assessment and as part of the evaluation of the person's capacity to consent for GAMSTs. Reproductive options should be considered and discussed prior to the initiation of gender-affirming treatments. Because the literature is unclear about the possibility of conception while on hormone therapy, information about the necessity of using contraception to avoid unwanted pregnancy and the different methods of contraception available may need to be provided (Light et al., 2014; Schubert & Carey, 2020).

Cross-sectional studies in clinical and nonclinical samples from different populations consistently report TGD adults express parental desire and wish to pursue fertility preservation with varying rates that are related to age, gender, and the duration of gender-affirming hormone treatment (Auer et al., 2018; De Sutter et al., 2002; Defreyne, Van Schuvlenbergh et al., 2020; Wierckx, Stuyver et al., 2012). In a small sample,

provision of fertility information was found to have an influence on decision-making related to the use of fertility preservation (Chen et al., 2019). Although there was no comparison made between groups who did and did not receive fertility counseling, high fertility preservation rates occurred following comprehensive fertility counseling among transgender individuals (Amir et al., 2020). Further, one study suggested consultation with a specialist reduced regret related to the decision about whether to pursue fertility preservation procedures (Vyas et al., 2021). For more information see Chapter 16—Reproductive Health.

#### Statement 5.4

**We suggest, as part of the assessment for gender-affirming hormonal or surgical treatment, professionals who have competencies in the assessment of transgender and gender diverse people wishing gender-related medical treatment consider the role of social transition together with the individual.**

Social transition can be extremely beneficial to many TGD people although not all TGD people are able to socially transition or wish to socially transition (Bränström & Pachankis, 2021; Koehler et al., 2018; Nieder, Eyssel et al., 2020). Consequently, some TGD people seek gender-affirming interventions after social transition, some before, some during, and some in the absence of social transition.

Social transition and gender identity disclosure can improve the mental health of a TGD person seeking gender-affirming interventions (Hughto et al., 2020; McDowell et al., 2019). In addition, chest and facial surgeries prior to hormone therapy can facilitate social transition (Altman, 2012; Davis & Colton Meier, 2014; Olson-Kennedy, Warus et al. 2018; Van Boerum et al., 2019). As part of the assessment process, HCPs should discuss which social role is most comfortable for the TGD person, if a social transition is planned, and the timing for any planned social transition (Barker & Wylie, 2008). It is imperative during the assessment process, HCPs are respectful of the wide diversity of gendered social roles, including nonbinary as well as binary identities and presentations, which vary

according to cultural, local community, and individual understandings.

Not everyone who requests GAMSTs will wish to or be able to socially transition. Little is known about TGD people who do not socially transition before, during, or after medical treatment, as this has not been systematically studied. The most frequent reasons that have been identified for avoiding social transition are fear of being abandoned by family or friends, fearing economic loss (Bradford et al., 2013), and being discriminated against and stigmatized (Langenderfer-Magruder et al., 2016; McDowell et al., 2019; White Hughto et al., 2015). However, some people do not pursue social transition because they feel hormonal or surgical treatments offer enough subjective improvement to reduce gender dysphoria.

If there is no clear plan for social transition or if social transition is unwanted, additional assessment is important to determine the specific nature and advisability of the treatment request, especially if surgical treatment is requested. Additional assessment can offer the TGD person an opportunity to consider the possible effects of not socially transitioning while still obtaining GAMSTs. Given the lack of data on health outcomes for TGD people who do not socially transition (Evans et al., 2021; Levine, 2009; Turban, Loo et al., 2021), GAMSTs should be approached cautiously in such circumstances.

#### Statement 5.5

**We recommend transgender and gender diverse adults who fulfill the criteria for gender-affirming medical and surgical treatment require a single opinion for the initiation of this treatment from a professional who has competencies in the assessment of transgender and gender diverse people wishing gender-related medical and surgical treatment.**

Previous versions of the SOC guidelines have required TGD individuals to be assessed for GAMSTs by two qualified HCPs. It was believed having two independent opinions was best practice as it ensured safety for both TGD people and HCPs. For example, it was assumed that seeing two HCPs offered assuredness for both TGD people and their assessing HCPs when pursuing irreversible medical interventions.

However, the limited research in the area indicates two opinions are largely unnecessary. For example, Jones, Brewin et al. (2017) reviewed the case notes of experienced HCPs working within a state-funded gender service and found there was an overwhelming correlation between both opinions—arguably making one of them redundant. Further, Bouman et al. (2014) determined the requirement for two independent assessors reflected paternalism in health care services and raised a potential breach of the autonomy of TGD individuals. The authors posited when clients are adequately prepared and assessed under the care of a multidisciplinary team, a second independent assessment is unnecessary.

Consequently, if written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST), TGD people seeking treatments including hormones, and genital, chest, facial and other gender-affirming surgeries require a single written opinion/signature from an HCP competent to independently assess and diagnose (Bouman et al., 2014; Yuan et al., 2021). Further written opinions/signatures may be requested where there is a specific clinical need.

#### Statement 5.6

**We suggest health care professionals assessing transgender and gender diverse people seeking gonadectomy consider a minimum of 6 months of hormone therapy as appropriate to the TGD person's gender goals before the TGD person undergoes irreversible surgical intervention (unless hormones are not clinically indicated for the individual).**

The Endocrine Society Clinical Practice Guidelines advise a period of consistent hormone treatment prior to genital surgery (Hembree et al., 2017). While there was limited supportive research, this recommendation was considered to be good clinical practice as it allows a more reversible experience prior to the irreversible experience of surgery. For example, there can be changes in sexual desire after genital surgery that removes the testicles (Lawrence, 2005; Wierckx, Van de Peer et al., 2014). In this context, reversible testosterone suppression can offer a TGD person a period of time to experience the absence of testosterone and decide if this feels right for

them. It should be noted the effects of reduced estrogen on a TGD person's sexual desire and functioning following an oophorectomy is less well documented.

Surgery that removes gonads is an irreversible procedure that leads to loss of fertility and loss of the effects of endogenous sex steroids. Both effects must be discussed as a component of the assessment process. For additional information see Chapter 16—Reproductive Health. Of course, hormones are not clinically indicated for TGD adults who do not want them or in cases where they are contraindicated due to health reasons. For more information see Chapter 13—Surgery and Postoperative Care.

#### Statement 5.7

**We recommend health care professionals assessing adults who wish to detransition and seek gender-related hormone intervention, surgical intervention, or both, utilize a comprehensive multidisciplinary assessment that will include additional viewpoints from experienced health care professionals in transgender health and that considers, together with the individual, the role of social transition as part of the assessment process.**

Many TGD adults may consider a range of identities and elements of gender presentation while they are exploring their gender identity and are considering transition options. Accordingly, people may spend some time in a gender identity or presentation before they discover it does not feel comfortable and later adapt it or shift to an earlier identity or presentation (Turban, King et al., 2021). Some TGD adults may also experience a change in gender identity over time so that their needs for medical treatment evolve. This is a healthy and reasonable process for determining the most comfortable and congruent way of living, which is informed by the person's gender identity and the context of their life. This process of identity exploration should not necessarily be equated with regret, confusion, or poor decision-making because a TGD adult's gender identity may change without devaluing previous transition decisions (MacKinnon et al., 2021; Turban, Loo et al., 2021). TGD adults should be assisted in this exploration and any other changes

in their identity (Expósito-Campos, 2021). While exploration continues, gender-affirming treatments that are irreversible should be avoided until clarity about long-term goals and outcomes is achieved.

The decision to detransition appears to be rare (Defreyne, Motmans et al., 2017; Hadje-Moussa et al., 2019; Wiepjes et al., 2018). Estimates of the number of people who detransition due to a change in identity are likely to be overinflated due to research blending different cohorts (Expósito-Campos, 2021). For example, detransition research cohorts often include TGD adults who chose to detransition because of a change in their identity as well as TGD adults who chose to detransition without a change in identity. While little research has been conducted to systematically examine variables that correlate with a TGD adult's decision to halt a transition process or to detransition, a recent study found the vast majority of TGD people who opted to detransition did so due to external factors, such as stigma and lack of social support and not because of changes in gender identity (Turban, King et al., 2021). TGD adults who have not experienced a change in identity may choose to halt transition or to detransition because of oppression, violence, and social/relational conflict, surgical complications, health concerns, physical contraindications, a lack of resources, or dissatisfaction with the results (Expósito-Campos, 2021). In such cases, MHPs are well placed to assist the TGD person with these challenges.

While the choice to detransition is proportionally rare, it is expected an overall increase in the number of adults who identify as TGD would result in an increase in the absolute number of people seeking to halt or reverse a transition. However, while the absolute numbers may increase, the percentage of people seeking to halt or reverse permanent physical changes should remain static and low. The existence of these rare requests must not be used as a justification to interrupt critical, medically necessary care, including hormone and surgical treatments, for the vast majority of TGD adults.

Due to the limited research in this area, clinical guidance is based primarily on individual case studies and the expert opinion of HCPs

working with TGD adults (Expósito-Campos, 2021; Richards & Barrett, 2020). Accordingly, if a TGD adult has undergone permanent physical changes and seeks to undo them, the assessing HCP should be a member of a comprehensive multidisciplinary assessment team. A multidisciplinary team allows for the contribution of additional viewpoints from HCPs experienced in transgender health. In collaboration with the TGD adult, the multidisciplinary team is encouraged to thoroughly understand the motivations for the original treatment and for the decision to detransition. Any concerns with the previous physical changes should be carefully explored and a significant effort made to ensure similar concerns are not replicated by the reversal.

To ensure the greatest likelihood of satisfaction and comfort with a reversal of permanent physical changes, the TGD adult and the multidisciplinary team should explore the role of social transition in the assessment and in preparation for the reversal. In such instances, it is highly likely a prolonged period of living in role will be necessary before further physical changes are recommended. HCPs should support the TGD adult through any social changes, as well as any feelings of failure, shame, depression, or guilt in deciding to make such a change. In addition, people should be supported in coping with any prejudice or social difficulties they may have experienced that could have led to a decision to detransition or that may have resulted from such a decision. It is also important to help the person remain engaged with health care throughout the process (Narayan et al., 2021).

While available research shows consistent positive outcomes for the majority of TGD adults who choose to transition (Aldridge et al., 2020; Byne et al., 2012; Gorin-Lazard et al., 2012; Owen-Smith et al., 2018; White Hughto & Reisner, 2016), some TGD adults may decompensate or experience a worsened condition following transition. Little research has been conducted to systematically examine variables that correlate with poor or worsened biological, psychological, or social conditions following transition (Hall et al., 2021; Littman, 2021); however, this occurrence appears to be rare (Hall et al., 2021; Wiepjes et al., 2018). In cases where people decompensate after physical or social transition and then remain in a poorer biological, psychological, or social state than they were in prior to transition, serious consideration should be given as to whether transition is helpful at this time, for this person, or both. In cases where treatment is no longer supported, assistance should be arranged to support the person to manage the process of stopping treatment and to manage any concomitant difficulties (Narayan et al., 2021).

It is vital that people who detransition, for any reason, be supported. It should be remembered, however, this is a rare occurrence and the literature shows consistently positive outcomes for the vast majority of TGD adults who transition to a gender that is comfortable for them, including those who receive GAMSTs (Byne et al., 2012; Green & Fleming, 1990; Lawrence, 2003; Motmans et al., 2012; Van de Grift, Elaut et al., 2018).

## CHAPTER 6 Adolescents

### *Historical context and changes since previous Standards of Care*

Specialized health care for transgender adolescents began in the 1980s when a few specialized gender clinics for youth were developed around the world that served relatively small numbers of children and adolescents. In more recent years, there has been a sharp increase in the number of adolescents requesting gender care (Arnoldussen et al., 2019; Kaltiala, Bergman et al., 2020). Since then, new clinics have been founded, but clinical services in many places have not kept pace with the increasing number of youth seeking care. Hence, there are often long waitlists for services, and barriers to care exist for many transgender youth around the world (Tollit et al., 2018).

Until recently, there was limited information regarding the prevalence of gender diversity among adolescents. Studies from high school samples indicate much higher rates than earlier thought, with reports of up to 1.2% of participants identifying as transgender (Clark et al., 2014) and up to 2.7% or more (e.g., 7–9%) experiencing some level of self-reported gender diversity (Eisenberg et al., 2017; Kidd et al., 2021; Wang et al., 2020). These studies suggest gender diversity in youth should no longer be viewed as rare. Additionally, a pattern of uneven ratios by assigned sex has been reported in gender clinics, with adolescents assigned female at birth (AFAB) initiating care 2.5–7.1 times more frequently as compared to adolescents who are assigned male at birth (AMAB) (Aitken et al., 2015; Arnoldussen et al., 2019; Bauer et al., 2021; de Graaf, Carmichael et al., 2018; Kaltiala et al., 2015; Kaltiala, Bergman et al., 2020).

A specific World Professional Association for Transgender Health's (WPATH) Standards of Care section dedicated to the needs of children and adolescents was first included in the 1998 WPATH Standards of Care, 5th version (Levine et al., 1998). Youth aged 16 or older were deemed potentially eligible for gender-affirming medical care, but only in select cases. The subsequent 6th (Meyer et al., 2005) and 7th (Coleman et al., 2012) versions divided medical-affirming treatment for adolescents into three categories and

presented eligibility criteria regarding age/puberty stage—namely fully reversible puberty delaying blockers as soon as puberty had started; partially reversible hormone therapy (testosterone, estrogen) for adolescents at the age of majority, which was age 16 in certain European countries; and irreversible surgeries at age 18 or older, except for chest “masculinizing” mastectomy, which had an age minimum of 16 years. Additional eligibility criteria for gender-related medical care included a persistent, long (childhood) history of gender “non-conformity”/dysphoria, emerging or intensifying at the onset of puberty; absence or management of psychological, medical, or social problems that interfere with treatment; provision of support for commencing the intervention by the parents/caregivers; and provision of informed consent. A chapter dedicated to transgender and gender diverse (TGD) adolescents, distinct from the child chapter, has been created for this 8<sup>th</sup> edition of the Standards of Care given 1) the exponential growth in adolescent referral rates; 2) the increased number of studies specific to adolescent gender diversity-related care; and 3) the unique developmental and gender-affirming care issues of this age group.

Non-specific terms for gender-related care are avoided (e.g., gender-affirming model, gender exploratory model) as these terms do not represent unified practices, but instead heterogenous care practices that are defined differently in various settings.

### *Adolescence overview*

Adolescence is a developmental period characterized by relatively rapid physical and psychological maturation, bridging childhood and adulthood (Sanders, 2013). Multiple developmental processes occur simultaneously, including pubertal-signaled changes. Cognitive, emotional, and social systems mature, and physical changes associated with puberty progress. These processes do not all begin and end at the same time for a given individual, nor do they occur at the same age for all persons. Therefore, the lower and upper borders of adolescence are imprecise and cannot be defined exclusively by age. For example, physical pubertal changes may

begin in late childhood and executive control neural systems continue to develop well into the mid-20s (Ferguson et al., 2021). There is a lack of uniformity in how countries and governments define the age of majority (i.e., legal decision-making status; Dick et al., 2014). While many specify the age of majority as 18 years of age, in some countries it is as young as 15 years (e.g., Indonesia and Myanmar), and in others as high as 21 years (e.g., the U.S. state of Mississippi and Singapore).

**For clarity, this chapter applies to adolescents from the start of puberty until the legal age of majority (in most cases 18 years), however there are developmental elements of this chapter, including the importance of parental/caregiver involvement, that are often relevant for the care of transitional-aged young adults and should be considered appropriately.**

Cognitive development in adolescence is often characterized by gains in abstract thinking, complex reasoning, and metacognition (i.e., a young person's ability to think about their own feelings in relation to how others perceive them; Sanders, 2013). The ability to reason hypothetical situations enables a young person to conceptualize implications regarding a particular decision. However, adolescence is also often associated with increased risk-taking behaviors. Along with these notable changes, adolescence is often characterized by individuation from parents and the development of increased personal autonomy. There is often a heightened focus on peer relationships, which can be both positive and detrimental (Gardner & Steinberg, 2005). Adolescents often experience a sense of urgency that stems from hypersensitivity to reward, and their sense of timing has been shown to be different from that of older individuals (Van Leijenhorst et al., 2010). Social-emotional development typically advances during adolescence, although there is a great variability among young people in terms of the level of maturity applied to inter- and intra-personal communication and insight (Grootens-Wiegers et al., 2017). For TGD adolescents making decisions about gender-affirming treatments—decisions that may have lifelong consequences—it is critical to understand how all these aspects of development may impact decision-making for a

given young person within their specific cultural context.

### ***Gender identity development in adolescence***

Our understanding of gender identity development in adolescence is continuing to evolve. When providing clinical care to gender diverse young people and their families, it is important to know what is and is not known about gender identity during development (Berenbaum, 2018). When considering treatments, families may have questions regarding the development of their adolescent's gender identity, and whether or not their adolescent's declared gender will remain the same over time. For some adolescents, a declared gender identity that differs from the assigned sex at birth comes as no surprise to their parents/caregivers as their history of gender diverse expression dates back to childhood (Leibowitz & de Vries, 2016). For others, the declaration does not happen until the emergence of pubertal changes or even well into adolescence (McCallion et al., 2021; Sorbara et al., 2020).

Historically, social learning and cognitive developmental research on gender development was conducted primarily with youth who were not gender diverse in identity or expression and was carried out under the assumption that sex correlated with a specific gender; therefore, little attention was given to gender identity development. In addition to biological factors influencing gender development, this research demonstrated psychological and social factors also play a role (Perry & Pauletti, 2011). While there has been less focus on gender identity development in TGD youth, there is ample reason to suppose, apart from biological factors, psychosocial factors are also involved (Steensma, Kreukels et al., 2013). For some youth, gender identity development appears fixed and is often expressed from a young age, while for others there may be a developmental process that contributes to gender identity development over time.

Neuroimaging studies, genetic studies, and other hormone studies in intersex individuals demonstrate a biological contribution to the development of gender identity for some

individuals whose gender identity does not match their assigned sex at birth (Steensma, Kreukels et al., 2013). As families often have questions about this very issue, it is important to note it is not possible to distinguish between those for whom gender identity may seem fixed from birth and those for whom gender identity development appears to be a developmental process. Since it is impossible to definitively delineate the contribution of various factors contributing to gender identity development for any given young person, a comprehensive clinical approach is important and necessary (see Statement 3). Future research would shed more light on gender identity development if conducted over long periods of time with diverse cohort groups. Conceptualization of gender identity by shifting from dichotomous (e.g., binary) categorization of male and female to a dimensional gender spectrum along a continuum (APA, 2013) would also be necessary.

Adolescence may be a critical period for the development of gender identity for gender diverse young people (Steensma, Kreukels et al., 2013). Dutch longitudinal clinical follow-up studies of adolescents with childhood gender dysphoria who received puberty suppression, gender-affirming hormones, or both, found that none of the youth in adulthood regretted the decisions they had taken in adolescence (Cohen-Kettenis & van Goozen, 1997; de Vries et al., 2014). These findings suggest adolescents who were comprehensively assessed and determined emotionally mature enough to make treatment decisions regarding gender-affirming medical care presented with stability of gender identity over the time period when the studies were conducted.

When extrapolating findings from the longer-term longitudinal Dutch cohort studies to present-day gender diverse adolescents seeking care, it is critical to consider the societal changes that have occurred over time in relation to TGD people. Given the increase in visibility of TGD identities, it is important to understand how increased awareness may impact gender development in different ways (Kornienko et al., 2016). One trend identified is that more young people are presenting to gender clinics with nonbinary identities (Twist & de Graaf, 2019). Another phenomenon occurring in clinical practice is the increased number of adolescents

seeking care who have not seemingly experienced, expressed (or experienced and expressed) gender diversity during their childhood years. One researcher attempted to study and describe a specific form of later-presenting gender diversity experience (Littman, 2018). However, the findings of the study must be considered within the context of significant methodological challenges, including 1) the study surveyed parents and not youth perspectives; and 2) recruitment included parents from community settings in which treatments for gender dysphoria are viewed with scepticism and are criticized. However, these findings have not been replicated. For a select subgroup of young people, susceptibility to social influence impacting gender may be an important differential to consider (Kornienko et al., 2016). However, caution must be taken to avoid assuming these phenomena occur prematurely in an individual adolescent while relying on information from datasets that may have been ascertained with potential sampling bias (Bauer et al., 2022; WPATH, 2018). It is important to consider the benefits that social connectedness may have for youth who are linked with supportive people (Tuzun et al., 2022)(see Statement 4).

Given the emerging nature of knowledge regarding adolescent gender identity development, an individualized approach to clinical care is considered both ethical and necessary. As is the case in all areas of medicine, each study has methodological limitations, and conclusions drawn from research cannot and should not be universally applied to all adolescents. This is also true when grappling with common parental questions regarding the stability versus instability of a particular young person's gender identity development. While future research will help advance scientific understanding of gender identity development, there may always be some gaps. Furthermore, given the ethics of self-determination in care, these gaps should not leave the TGD adolescent without important and necessary care.

### ***Research evidence of gender-affirming medical treatment for transgender adolescents***

A key challenge in adolescent transgender care is the quality of evidence evaluating the effectiveness of medically necessary gender-affirming medical

and surgical treatments (GAMSTs) (see medically necessary statement in the Global chapter, Statement 2.1), over time. Given the lifelong implications of medical treatment and the young age at which treatments may be started, adolescents, their parents, and care providers should be informed about the nature of the evidence base. It seems reasonable that decisions to move forward with medical and surgical treatments should be made carefully. Despite the slowly growing body of evidence supporting the effectiveness of early medical intervention, the number of studies is still low, and there are few outcome studies that follow youth into adulthood. Therefore, a systematic review regarding outcomes of treatment in adolescents is not possible. A short narrative review is provided instead.

At the time of this chapter's writing, there were several longer-term longitudinal cohort follow-up studies reporting positive results of early (i.e., adolescent) medical treatment; for a significant period of time, many of these studies were conducted through one Dutch clinic (e.g., Cohen-Kettenis & van Goozen, 1997; de Vries, Steensma et al., 2011; de Vries et al., 2014; Smith et al., 2001, 2005). The findings demonstrated the resolution of gender dysphoria is associated with improved psychological functioning and body image satisfaction. Most of these studies followed a pre-post methodological design and compared baseline psychological functioning with outcomes after the provision of medical gender-affirming treatments. Different studies evaluated individual aspects or combinations of treatment interventions and included 1) gender-affirming hormones and surgeries (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001, 2005); 2) puberty suppression (de Vries, Steensma et al., 2011); and 3) puberty suppression, affirming hormones, and surgeries (de Vries et al., 2014). The 2014 long-term follow-up study is the only study that followed youth from early adolescence (pretreatment, mean age of 13.6) through young adulthood (posttreatment, mean age of 20.7). This was the first study to show gender-affirming treatment enabled transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with satisfactory objective and

subjective outcomes in adulthood (de Vries et al., 2014). While the study employed a small ( $n = 55$ ), select, and socially supported sample, the results were convincing. Of note, the participants were part of the Dutch clinic known for employing a multidisciplinary approach, including provision of comprehensive, ongoing assessment and management of gender dysphoria, and support aimed at emotional well-being.

Several more recently published longitudinal studies followed and evaluated participants at different stages of their gender-affirming treatments. In these studies, some participants may not have started gender-affirming medical treatments, some had been treated with puberty suppression, while still others had started gender-affirming hormones or had even undergone gender-affirming surgery (GAS) (Achille et al., 2020; Allen et al., 2019; Becker-Hebly et al., 2021; Carmichael et al., 2021; Costa et al., 2015; Kuper et al., 2020, Tordoff et al., 2022). Given the heterogeneity of treatments and methods, this type of design makes interpreting outcomes more challenging. Nonetheless, when compared with baseline assessments, the data consistently demonstrate improved or stable psychological functioning, body image, and treatment satisfaction varying from three months to up to two years from the initiation of treatment.

Cross-sectional studies provide another design for evaluating the effects of gender-affirming treatments. One such study compared psychological functioning in transgender adolescents at baseline and while undergoing puberty suppression with that of cisgender high school peers at two different time points. At baseline, the transgender youth demonstrated lower psychological functioning compared with cisgender peers, whereas when undergoing puberty suppression, they demonstrated better functioning than their peers (van der Miesen et al., 2020). Grannis et al. (2021) demonstrated transgender males who started testosterone had lower internalizing mental health symptoms (depression and anxiety) compared with those who had not started testosterone treatment.

Four additional studies followed different outcome designs. In a retrospective chart study, Kaltiala, Heino et al. (2020) reported transgender

adolescents with few or no mental health challenges prior to commencing gender-affirming hormones generally did well during the treatment. However, adolescents with more mental health challenges at baseline continued to experience the manifestations of those mental health challenges over the course of gender-affirming medical treatment. Nieder et al. (2021) studied satisfaction with care as an outcome measure and demonstrated transgender adolescents were more satisfied the further they progressed with the treatments they initially started. Hisle-Gorman et al. (2021) compared health care utilization pre- and post-initiation of gender-affirming pharmaceuticals as indicators of the severity of mental health conditions among 3,754 TGD adolescents in a large health care data set. Somewhat contrary to the authors' hypothesis of improved mental health, mental health care use did not significantly change, and psychotropic medication prescriptions increased. In a large non-probability sample of transgender-identified adults, Turban et al. (2022) found those who reported access to gender-affirming hormones in adolescence had lower odds of past-year suicidality compared with transgender people accessing gender-affirming hormones in adulthood.

Providers may consider the possibility an adolescent may regret gender-affirming decisions made during adolescence, and a young person will want to stop treatment and return to living in the birth-assigned gender role in the future. Two Dutch studies report low rates of adolescents (1.9% and 3.5%) choosing to stop puberty suppression (Brik et al., 2019; Wiepjes et al., 2018). Again, these studies were conducted in clinics that follow a protocol that includes a comprehensive assessment before the gender-affirming medical treatment is started. At present, no clinical cohort studies have reported on profiles of adolescents who regret their initial decision or detransition after irreversible affirming treatment. Recent research indicate there are adolescents who detransition, but do not regret initiating treatment as they experienced the start of treatment as a part of understanding their gender-related care needs (Turban, 2018). However, this may not be the predominant perspective of people who

detransition (Littman, 2021; Vandebussche, 2021). Some adolescents may regret the steps they have taken (Dyer, 2020). Therefore, it is important to present the full range of possible outcomes when assisting transgender adolescents. Providers may discuss this topic in a collaborative and trusting manner (i.e., as a "potential future experience and consideration") with the adolescent and their parents/caregivers before gender-affirming medical treatments are started. Also, providers should be prepared to support adolescents who detransition. In an internet convenience sample survey of 237 self-identified detransitioners with a mean age of 25.02 years, which consisted of over 90% of birth assigned females, 25% had medically transitioned before age 18 and 14% detransitioned before age 18 (Vandebussche, 2021). Although an internet convenience sample is subject to selection of respondents, this study suggests detransitioning may occur in young transgender adolescents and health care professionals should be aware of this. Many of them expressed difficulties finding help during their detransition process and reported their detransition was an isolating experience during which they did not receive either sufficient or appropriate support (Vandebussche, 2021).

To conclude, although the existing samples reported on relatively small groups of youth (e.g.,  $n = 22-101$  per study) and the time to follow-up varied across studies (6 months–7 years), this emerging evidence base indicates a general improvement in the lives of transgender adolescents who, following careful assessment, receive medically necessary gender-affirming medical treatment. Further, rates of reported regret during the study monitoring periods are low. Taken as a whole, the data show early medical intervention—as part of broader combined assessment and treatment approaches focused on gender dysphoria and general well-being—can be effective and helpful for many transgender adolescents seeking these treatments.

### ***Ethical and human rights perspectives***

Medical ethics and human rights perspectives were also considered while formulating the

**Statements of Recommendations**

- 6.1- We recommend health care professionals working with gender diverse adolescents:
- 6.1.a- Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.
- 6.1.b- Receive theoretical and evidenced-based training and develop expertise in general child, adolescent, and family mental health across the developmental spectrum.
- 6.1.c- Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.
- 6.1.d- Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.
- 6.1.e- Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.
- 6.2- We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.
- 6.3- We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.
- 6.4- We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.
- 6.5- We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.
- 6.6- We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including a review of the benefits and risks.
- 6.7- We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.
- 6.8- We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.
- 6.9- We recommend health care professionals involve relevant disciplines, including mental health and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.
- 6.10- We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to initiating treatment, of the reproductive effects including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.
- 6.11- We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.

*The following recommendations are made regarding the requirements for gender-affirming medical and surgical treatment (All of them must be met):*

- 6.12- We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:
- 6.12.a- The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.
- 6.12.b- The experience of gender diversity/incongruence is marked and sustained over time.
- 6.12.c- The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.
- 6.12.d- The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed.
- 6.12.e- The adolescent has been informed of the reproductive effects, including the potential loss of fertility and the available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.
- 6.12.f- The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.
- 6.12.g- The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.

adolescent SOC statements. For example, allowing irreversible puberty to progress in adolescents who experience gender incongruence is not a neutral act given that it may have immediate and lifelong harmful effects for the transgender young person (Giordano, 2009; Giordano

& Holm, 2020; Kreukels & Cohen-Kettenis, 2011). From a human rights perspective, considering gender diversity as a normal and expected variation within the broader diversity of the human experience, it is an adolescent's right to participate in their own decision-making

process about their health and lives, including access to gender health services (Amnesty International, 2020).

### **Short summary of statements and unique issues in adolescence**

These guidelines are designed to account for what is known and what is not known about gender identity development in adolescence, the evidence for gender-affirming care in adolescence, and the unique aspects that distinguish adolescence from other developmental stages.

*Identity exploration:* A defining feature of adolescence is the solidifying of aspects of identity, including gender identity. Statement 6.2 addresses identity exploration in the context of gender identity development. Statement 6.12.b accounts for the length of time needed for a young person to experience a gender diverse identity, express a gender diverse identity, or both, so as to make a meaningful decision regarding gender-affirming care.

*Consent and decision-making:* In adolescence, consent and decision-making require assessment of the individual's emotional, cognitive, and psychosocial development. Statement 6.12.c directly addresses emotional and cognitive maturity and describes the necessary components of the evaluation process used to assess decision-making capacity.

*Caregivers/parent involvement:* Adolescents are typically dependent on their caregivers/parents for guidance in numerous ways. This is also true as the young person navigates through the process of deciding about treatment options. Statement 6.11 addresses the importance of involving caregivers/parents and discusses the role they play in the assessment and treatment. No set of guidelines can account for every set of individual circumstances on a global scale.

#### Statement 6.1

**We recommend health care professionals working with gender diverse adolescents:**

- a. Are licensed by their statutory body and hold a postgraduate degree or its equivalent in a clinical field relevant to this role granted by a nationally accredited statutory institution.**
- b. Receive theoretical and evidenced-based training and develop expertise in general**

**child, adolescent, and family mental health across the developmental spectrum.**

- c. Receive training and have expertise in gender identity development, gender diversity in children and adolescents, have the ability to assess capacity to assent/consent, and possess general knowledge of gender diversity across the life span.**
- d. Receive training and develop expertise in autism spectrum disorders and other neurodevelopmental presentations or collaborate with a developmental disability expert when working with autistic/neurodivergent gender diverse adolescents.**
- e. Continue engaging in professional development in all areas relevant to gender diverse children, adolescents, and families.**

When assessing and supporting TGD adolescents and their families, care providers/health care professionals (HCPs) need both general as well as gender-specific knowledge and training. Providers who are trained to work with adolescents and families play an important role in navigating aspects of adolescent development and family dynamics when caring for youth and families (Adelson et al., 2012; American Psychological Association, 2015; Hembree et al., 2017). Other chapters in these standards of care describe these criteria for professionals who provide gender care in more detail (see Chapter 5—Assessment for Adults; Chapter 7—Children; or Chapter 13—Surgery and Postoperative Care). Professionals working with adolescents should understand what is and is not known regarding adolescent gender identity development, and how this knowledge base differs from what applies to adults and prepubertal children. Among HCPs, the mental health professional (MHP) has the most appropriate training and dedicated clinical time to conduct an assessment and elucidate treatment priorities and goals when working with transgender youth, including those seeking gender-affirming medical/surgical care. Understanding and managing the dynamics of family members who may share differing perspectives regarding the history and needs of the

young person is an important competency that MHPs are often most prepared to address.

When access to professionals trained in child and adolescent development is not possible, HCPs should make a commitment to obtain training in the areas of family dynamics and adolescent development, including gender identity development. Similarly, considering autistic/neurodivergent transgender youth represent a substantial minority subpopulation of youth served in gender clinics globally, it is important HCPs seek additional training in the field of autism and understand the unique elements of care autistic gender diverse youth may require (Strang, Meagher et al., 2018). If these qualifications are not possible, then consultation and collaboration with a provider who specializes in autism and neurodiversity is advised.

#### Statement 6.2

**We recommend health care professionals working with gender diverse adolescents facilitate the exploration and expression of gender openly and respectfully so that no one particular identity is favored.**

Adolescence is a developmental period that involves physical and psychological changes characterized by individuation and the transition to independence from caregivers (Berenbaum et al., 2015; Steinberg, 2009). It is a period during which young people may explore different aspects of identity, including gender identity.

Adolescents differ regarding the degree to which they explore and commit to aspects of their identity (Meeus et al., 2012). For some adolescents, the pace to achieving consolidation of identity is fast, while for others it is slower. For some adolescents, physical, emotional, and psychological development occur over the same general timeline, while for others, there are certain gaps between these aspects of development. Similarly, there is variation in the timeline for gender identity development (Arnoldussen et al., 2020; Katz-Wise et al., 2017). For some young people, gender identity development is a clear process that starts in early childhood, while for others pubertal changes contribute to a person's experience of themselves as a particular gender (Steensma, Kreukels et al., 2013), and for many others a process may begin well after pubertal

changes are completed. Given these variations, there is no one particular pace, process, or outcome that can be predicted for an individual adolescent seeking gender-affirming care.

Therefore, HCPs working with adolescents should promote supportive environments that simultaneously respect an adolescent's affirmed gender identity and also allows the adolescent to openly explore gender needs, including social, medical, and physical gender-affirming interventions should they change or evolve over time.

#### Statement 6.3

**We recommend health care professionals working with gender diverse adolescents undertake a comprehensive biopsychosocial assessment of adolescents who present with gender identity-related concerns and seek medical/surgical transition-related care, and that this be accomplished in a collaborative and supportive manner.**

Given the many ways identity may unfold during adolescence, we recommend using a comprehensive biopsychosocial assessment to guide treatment decisions and optimize outcomes. This assessment should aim to understand the adolescent's strengths, vulnerabilities, diagnostic profile, and unique needs to individualize their care. As mentioned in Statement 6.1, MHPs have the most appropriate training, experience, and dedicated clinical time required to obtain the information discussed here. The assessment process should be approached collaboratively with the adolescent and their caregiver(s), both separately and together, as described in more detail in Statement 6.11. An assessment should occur prior to any medically necessary medical or surgical intervention under consideration (e.g., puberty blocking medication, gender-affirming hormones, surgeries). See medically necessary statement in Chapter 2—Global Applicability, Statement 2.1; see also Chapter 12—Hormone Therapy and Chapter 13—Surgery and Postoperative Care.

Youth may experience many different gender identity trajectories. Sociocultural definitions and experiences of gender continue to evolve over time, and youth are increasingly presenting with a range of identities and ways of describing their experiences and gender-related needs (Twist & de

Graaf, 2019). For example, some youth will realize they are transgender or more broadly gender diverse and pursue steps to present accordingly. For some youth, obtaining gender-affirming medical treatment is important while for others these steps may not be necessary. For example, a process of exploration over time might not result in the young person self-affirming or embodying a different gender in relation to their assigned sex at birth and would not involve the use of medical interventions (Arnoldussen et al., 2019).

The most robust longitudinal evidence supporting the benefits of gender-affirming medical and surgical treatments in adolescence was obtained in a clinical setting that incorporated a detailed comprehensive diagnostic assessment process over time into its delivery of care protocol (de Vries & Cohen-Kettenis, 2012; de Vries et al., 2014). Given this research and the ongoing evolution of gender diverse experiences in society, a comprehensive diagnostic biopsychosocial assessment during adolescence is both evidence-based and preserves the integrity of the decision-making process. In the absence of a full diagnostic profile, other mental health entities that need to be prioritized and treated may not be detected. There are no studies of the long-term outcomes of gender-related medical treatments for youth who have not undergone a comprehensive assessment. Treatment in this context (e.g., with limited or no assessment) has no empirical support and therefore carries the risk that the decision to start gender-affirming medical interventions may not be in the long-term best interest of the young person at that time.

As delivery of health care and access to specialists varies globally, designing a particular assessment process to adapt existing resources is often necessary. In some cases, a more extended assessment process may be useful, such as for youth with more complex presentations (e.g., complicating mental health histories (Leibowitz & de Vries, 2016)), co-occurring autism spectrum characteristics (Strang, Powers et al., 2018), and/or an absence of experienced childhood gender incongruence (Ristori & Steensma, 2016). Given the unique cultural, financial, and geographical factors that exist for specific populations, providers should design assessment models that are flexible and allow for appropriately timed care for as many

young people as possible, so long as the assessment effectively obtains information about the adolescent's strengths, vulnerabilities, diagnostic profile, and individual needs. Psychometrically validated psychosocial and gender measures can also be used to provide additional information.

The multidisciplinary assessment for youth seeking gender-affirming medical/surgical interventions includes the following domains that correspond to the relevant statements:

- **Gender Identity Development:** Statements 6.12.a and 6.12.b elaborate on the factors associated with gender identity development within the specific cultural context when assessing TGD adolescents.
- **Social Development and Support; Intersectionality:** Statements 6.4 and 6.11 elaborate on the importance of assessing gender minority stress, family dynamics, and other aspects contributing to social development and intersectionality.
- **Diagnostic Assessment of Possible Co-Occurring Mental Health and/or Developmental Concerns:** Statement 6.12.d elaborates on the importance of understanding the relationship that exists, if at all, between any co-occurring mental health or developmental concerns and the young person's gender identity/gender diverse expression.
- **Capacity for Decision-Making:** Statement 6.12.c elaborates on the assessment of a young person's emotional maturity and the relevance when an adolescent is considering gender affirming-medical/surgical treatments.

#### Statement 6.4

**We recommend health care professionals work with families, schools, and other relevant settings to promote acceptance of gender diverse expressions of behavior and identities of the adolescent.**

Multiple studies and related expert consensus support the implementation of approaches that promote acceptance and affirmation of gender diverse youth across all settings, including families, schools, health care facilities, and all other organizations and communities with which they

interact (e.g., Pariseau et al., 2019; Russell et al., 2018; Simons et al., 2013; Toomey et al., 2010; Travers et al., 2012). Acceptance and affirmation are accomplished through a range of approaches, actions, and policies we recommend be enacted across the various relationships and settings in which a young person exists and functions. It is important for the family members and community members involved in the adolescent's life to work collaboratively in these efforts unless their involvement is considered harmful to the adolescent. Examples proposed by Pariseau et al. (2019) and others of acceptance and affirmation of gender diversity and contemplation and expression of identity that can be implemented by family, staff, and organizations include:

1. Actions that are supportive of youth drawn to engaging in gender-expansive (e.g., non-conforming) activities and interests;
2. Communications that are supportive when youth express their experiences about their gender and gender exploration;
3. Use of the youth's asserted name/pronouns;
4. Support for youth wearing clothing/uniforms, hairstyles, and items (e.g., jewelry, makeup) they feel affirm their gender;
5. Positive and supportive communication with youth about their gender and gender concerns;
6. Education about gender diversity issues for people in the young person's life (e.g., family members, health care providers, social support networks), as needed, including information about how to advocate for gender diverse youth in community, school, health care, and other settings;
7. Support for gender diverse youth to connect with communities of support (e.g., LGBTQ groups, events, friends);
8. Provision of opportunities to discuss, consider, and explore medical treatment options when indicated;
9. Antibullying policies that are enforced;
10. Inclusion of nonbinary experiences in daily life, reading materials, and curricula (e.g., books, health, and sex education classes, assigned essay topics that move beyond the binary, LGBTQ, and ally groups);

11. Gender inclusive facilities that the youth can readily access without segregation from nongender diverse peers (e.g., bathrooms, locker rooms).

We recommend HCPs work with parents, schools, and other organizations/groups to promote acceptance and affirmation of TGD identities and expressions, whether social or medical interventions are implemented or not as acceptance and affirmation are associated with fewer negative mental health and behavioral symptoms and more positive mental health and behavioral functioning (Day et al., 2015; de Vries et al., 2016; Greytak et al., 2013; Pariseau et al., 2019; Peng et al., 2019; Russell et al., 2018; Simons et al., 2013; Taliaferro et al., 2019; Toomey et al., 2010; Travers et al., 2012). Russell et al. (2018) found mental health improvement increases with more acceptance and affirmation across more settings (e.g., home, school, work, and friends). Rejection by family, peers, and school staff (e.g., intentionally using the name and pronoun the youth does not identify with, not acknowledging affirmed gender identity, bullying, harassment, verbal and physical abuse, poor relationships, rejection for being TGD, eviction) was strongly linked to negative outcomes, such as anxiety, depression, suicidal ideation, suicide attempts, and substance use (Grossman et al., 2005; Klein & Golub; 2016; Pariseau et al., 2019; Peng et al., 2019; Reisner, Greytak et al., 2015; Roberts et al., 2013). It is important to be aware that negative symptoms increase with increased levels of rejection and continue into adulthood (Roberts et al., 2013).

Neutral or indifferent responses to a youth's gender diversity and exploration (e.g., letting a child tell others their chosen name but not using the name, not telling family or friends when the youth wants them to disclose, not advocating for the child about rejecting behavior from school staff or peers, not engaging or participating in other support mechanisms (e.g., with psychotherapists and support groups) have also been found to have negative consequences, such as increased depressive symptoms (Pariseau et al., 2019). For these reasons, it is important not to ignore a youth's gender questioning or delay consideration of the youth's gender-related

care needs. There is particular value in professionals recognizing youth need individualized approaches, support, and consideration of needs around gender expression, identity, and embodiment over time and across domains and relationships. Youth may need help coping with the tension of tolerating others' processing/adjusting to an adolescent's identity exploration and changes (e.g., Kuper, Lindley et al., 2019). It is important professionals collaborate with parents and others as they process their concerns and feelings and educate themselves about gender diversity because such processes may not necessarily reflect rejection or neutrality but may rather represent efforts to develop attitudes and gather information that foster acceptance (e.g., Katz-Wise et al., 2017).

#### Statement 6.5

**We recommend against offering reparative and conversion therapy aimed at trying to change a person's gender and lived gender expression to become more congruent with the sex assigned at birth.**

Some health care providers, secular or religious organizations, and rejecting families may undertake efforts to thwart an adolescent's expression of gender diversity or assertion of a gender identity other than the expression and behavior that conforms to the sex assigned at birth. Such efforts at blocking reversible social expression or transition may include choosing not to use the youth's identified name and pronouns or restricting self-expression in clothing and hairstyles (Craig et al., 2017; Green et al., 2020). These disaffirming behaviors typically aim to reinforce views that a young person's gender identity/expression must match the gender associated with the sex assigned at birth or expectations based on the sex assigned at birth. Activities and approaches (sometimes referred to as "treatments") aimed at trying to change a person's gender identity and expression to become more congruent with the sex assigned at birth have been attempted, but these approaches have not resulted in changes in gender identity (Craig et al., 2017; Green et al., 2020). We recommend against such efforts because they have been found to be ineffective

and are associated with increases in mental illness and poorer psychological functioning (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020).

Much of the research evaluating "conversion therapy" and "reparative therapy" has investigated the impact of efforts to change gender expression (masculinity or femininity) and has conflated sexual orientation with gender identity (APA, 2009; Burnes et al., 2016; Craig et al., 2017). Some of these efforts have targeted both gender identity and expression (AACAP, 2018). Conversion/reparative therapy has been linked to increased anxiety, depression, suicidal ideation, suicide attempts, and health care avoidance (Craig et al., 2017; Green et al., 2020; Turban, Beckwith et al., 2020). Although some of these studies have been criticized for their methodologies and conclusions (e.g., D'Angelo et al., 2020), this should not detract from the importance of emphasizing efforts undertaken a priori to change a person's identity are clinically and ethically unsound. We recommend against any type of conversion or attempts to change a person's gender identity because 1) both secular and religion-based efforts to change gender identity/expression have been associated with negative psychological functioning that endures into adulthood (Turban, Beckwith et al., 2020); and 2) larger ethical reasons exist that should underscore respect for gender diverse identities.

It is important to note potential factors driving a young person's gender-related experience and report of gender incongruence, when carried out in the context of supporting an adolescent with self-discovery, is not considered reparative therapy as long as there is no a priori goal to change or promote one particular gender identity or expression (AACAP, 2018; see Statement 6.2). To ensure these explorations are therapeutic, we recommend employing affirmative consideration and supportive tone in discussing what steps have been tried, considered, and planned for a youth's gender expression. These discussion topics may include what felt helpful or affirming, what felt unhelpful or distressing and why. We recommend employing affirmative responses to these steps and discussions, such as those identified in SOC-8 Statement 6.4.

Statement 6.6

**We suggest health care professionals provide transgender and gender diverse adolescents with health education on chest binding and genital tucking, including review of the benefits and risks.**

TGD youth may experience distress related to chest and genital anatomy. Practices such as chest binding, chest padding, genital tucking, and genital packing are reversible, nonmedical interventions that may help alleviate this distress (Callen-Lorde, 2020a, 2020b; Deutsch, 2016a; Olson-Kennedy, Rosenthal et al., 2018; Transcare BC, 2020). It is important to assess the degree of distress related to physical development or anatomy, educate youth about potential nonmedical interventions to address this distress, and discuss the safe use of these interventions.

Chest binding involves compression of the breast tissue to create a flatter appearance of the chest. Studies suggest that up to 87% of trans masculine patients report a history of binding (Jones, 2015; Peitzmeier, 2017). Binding methods may include the use of commercial binders, sports bras, layering of shirts, layering of sports bras, or the use of elastics or other bandages (Peitzmeier, 2017). Currently, most youth report learning about binding practices from online communities composed of peers (Julian, 2019). Providers can play an important role in ensuring youth receive accurate and reliable information about the potential benefits and risks of chest binding. Additionally, providers can counsel patients about safe binding practices and monitor for potential negative health effects. While there are potential negative physical impacts of binding, youth who bind report many benefits, including increased comfort, improved safety, and lower rates of misgendering (Julian, 2019). Common negative health impacts of chest binding in youth include back/chest pain, shortness of breath, and overheating (Julian, 2019). More serious negative health impacts such as skin infections, respiratory infections, and rib fractures are uncommon and have been associated with chest binding in adults (Peitzmeier, 2017). If binding is employed, youth should be advised to use only those methods considered safe for binding—such as binders specifically designed for the

gender diverse population—to reduce the risk of serious negative health effects. Methods that are considered unsafe for binding include the use of duct tape, ace wraps, and plastic wrap as these can restrict blood flow, damage skin, and restrict breathing. If youth report negative health impacts from chest binding, these should ideally be addressed by a gender-affirming medical provider with experience working with TGD youth.

Genital tucking is the practice of positioning the penis and testes to reduce the outward appearance of a genital bulge. Methods of tucking include tucking the penis and testes between the legs or tucking the testes inside the inguinal canal and pulling the penis back between the legs. Typically, genitals are held in place by underwear or a gaff, a garment that can be made or purchased. Limited studies are available on the specific risks and benefits of tucking in adults, and none have been carried out in youth. Previous studies have reported tight undergarments are associated with decreased sperm concentration and motility. In addition, elevated scrotal temperatures can be associated with poor sperm characteristics, and genital tucking could theoretically affect spermatogenesis and fertility (Marsh, 2019) although there are no definitive studies evaluating these adverse outcomes. Further research is needed to determine the specific benefits and risks of tucking in youth.

Statement 6.7

**We recommend providers consider prescribing menstrual suppression agents for adolescents experiencing gender incongruence who may not desire testosterone therapy, who desire but have not yet begun testosterone therapy, or in conjunction with testosterone therapy for breakthrough bleeding.**

When discussing the available options of menstrual-suppressing medications with gender diverse youth, providers should engage in shared decision-making, use gender-inclusive language (e.g., asking patients which terms they utilize to refer to their menses, reproductive organs, and genitalia) and perform physical exams in a sensitive, gender-affirmative manner (Bonnington et al., 2020; Krempasky et al., 2020). There is no formal research evaluating how menstrual

suppression may impact gender incongruence and/or dysphoria. However, the use of menstrual suppression can be an initial intervention that allows for further exploration of gender-related goals of care, prioritization of other mental health care, or both, especially for those who experience a worsening of gender dysphoria from unwanted uterine bleeding (see Statement 6.12d; Mehringer & Dowshen, 2019). When testosterone is not used, menstrual suppression can be achieved via a progestin. To exclude any underlying menstrual disorders, it is important to obtain a detailed menstrual history and evaluation prior to implementing menstrual-suppressing therapy (Carswell & Roberts, 2017). As part of the discussion about menstrual-suppressing medications, the need for contraception and information regarding the effectiveness of menstrual-suppressing medications as methods of contraception also need to be addressed (Bonnington et al., 2020). A variety of menstrual suppression options, such as combined estrogen-progestin medications, oral progestins, depot and subdermal progestin, and intrauterine devices (IUDs), should be offered to allow for individualized treatment plans while properly considering availability, cost and insurance coverage, as well as contraindications and side effects (Kanj et al., 2019).

Progestin-only hormonal medication are options, especially in trans masculine or nonbinary youth who are not interested in estrogen-containing medical therapies as well as those at risk for thromboembolic events or who have other contraindications to estrogen therapy (Carswell & Roberts, 2017). Progestin-only hormonal medications include oral progestins, depo-medroxyprogesterone injection, etonogestrel implant, and levonorgestrel IUD (Schwartz et al., 2019). Progestin-only hormonal options vary in terms of efficacy in achieving menstrual suppression and have lower rates of achieving amenorrhea than combined oral contraception (Pradhan & Gomez-Lobo, 2019). A more detailed description of the relevant clinical studies is presented in Chapter 12—Hormone Therapy. HCPs should not make assumptions regarding the individual's preferred method of administration as some trans masculine youth may prefer vaginal rings or IUD implants (Akgul et al., 2019). Although hormonal

medications require monitoring for potential mood lability, depressive effects, or both, the benefits and risks of untreated menstrual suppression in the setting of gender dysphoria should be evaluated on an individual basis. Some patients may opt for combined oral contraception that includes different combinations of ethinyl estradiol, with ranging doses, and different generations of progestins (Pradhan & Gomez-Lobo, 2019). Lower dose ethinyl estradiol components of combined oral contraceptive pills are associated with increased breakthrough uterine bleeding. Continuous combined oral contraceptives may be used to allow for continuous menstrual suppression and can be delivered as transdermal or vaginal rings.

The use of gonadotropin releasing hormone (GnRH) analogues may also result in menstrual suppression. However, it is recommended gender diverse youth meet the eligibility criteria (as outlined in Statement 6.12) before this medication is considered solely for this purpose (Carswell & Roberts, 2017; Pradhan & Gomez-Lobo, 2019). Finally, menstrual-suppression medications may be indicated as an adjunctive therapy for breakthrough uterine bleeding that may occur while on exogenous testosterone or as a bridging medication while awaiting menstrual suppression with testosterone therapy. When exogenous testosterone is employed as a gender-affirming hormone, menstrual suppression is typically achieved in the first six months of therapy (Ahmad & Leinung, 2017). However, it is vital adolescents be counseled ovulation and pregnancy can still occur in the setting of amenorrhea (Gomez et al., 2020; Kanj et al., 2019).

#### Statement 6.8

**We recommend health care professionals maintain an ongoing relationship with the gender diverse and transgender adolescent and any relevant caregivers to support the adolescent in their decision-making throughout the duration of puberty suppression treatment, hormonal treatment, and gender-related surgery until the transition is made to adult care.**

HCPs with expertise in child and adolescent development, as described in Statement 6.1, play an important role in the continuity of care for

young people over the course of their gender-related treatment needs. Supporting adolescents and their families necessitates approaching care using a developmental lens through which understanding a young person's evolving emotional maturity and care needs can take place over time. As gender-affirming treatment pathways differ based on the needs and experiences of individual TGD adolescents, decision-making for these treatments (puberty suppression, estrogens/androgens, gender-affirmation surgeries) can occur at different points in time within a span of several years. Longitudinal research demonstrating the benefits of pubertal suppression and gender-affirming hormone treatment (GAHT) was carried out in a setting where an ongoing clinical relationship between the adolescents/families and the multidisciplinary team was maintained (de Vries et al., 2014).

Clinical settings that offer longer appointment times provide space for adolescents and caregivers to share important psychosocial aspects of emotional well-being (e.g., family dynamics, school, romantic, and sexual experiences) that contextualize individualized gender-affirming treatment needs and decisions as described elsewhere in the chapter. An ongoing clinical relationship can take place across settings, whether that be within a multidisciplinary team or with providers in different locations who collaborate with one another. Given the wide variability in the ability to obtain access to specialized gender care centers, particularly for marginalized groups who experience disparities with access, it is important for the HCP to appreciate the existence of any barriers to care while maintaining flexibility when defining how an ongoing clinical relationship can take place in that specific context.

An ongoing clinical relationship that increases resilience in the youth and provides support to parents/caregivers who may have their own treatment needs may ultimately lead to increased parental acceptance—when needed—which is associated with better mental health outcomes in youth (Ryan, Huebner et al., 2009).

#### Statement 6.9

**We recommend health care professionals involve relevant disciplines, including mental health**

**and medical professionals, to reach a decision about whether puberty suppression, hormone initiation, or gender-related surgery for gender diverse and transgender adolescents are appropriate and remain indicated throughout the course of treatment until the transition is made to adult care.**

TGD adolescents with gender dysphoria/gender incongruence who seek gender-affirming medical and surgical treatments benefit from the involvement of health care professionals (HCPs) from different disciplines. Providing care to TGD adolescents includes addressing 1) diagnostic considerations (see Statements 6.3, 6.12a, and 6.12b) conducted by a specialized gender HCP (as defined in Statement 6.1) whenever possible and necessary; and 2) treatment considerations when prescribing, managing, and monitoring medications for gender-affirming medical and surgical care, requiring the training of the relevant medical/surgical professional. The list of key disciplines includes but is not limited to adolescent medicine/primary care, endocrinology, psychology, psychiatry, speech/language pathology, social work, support staff, and the surgical team.

The evolving evidence has shown a clinical benefit for transgender youth who receive their gender-affirming treatments in multidisciplinary gender clinics (de Vries et al., 2014; Kuper et al., 2020; Tollit et al., 2019). Finally, adolescents seeking gender-affirming care in multidisciplinary clinics are presenting with significant complexity necessitating close collaboration between mental health, medical, and/or surgical professionals (McCallion et al., 2021; Sorbara et al., 2020; Tishelman et al., 2015).

As not all patients and families are in the position or in a location to access multidisciplinary care, the lack of available disciplines should not preclude a young person from accessing needed care in a timely manner. When disciplines are available, particularly in centers with existing multidisciplinary teams, disciplines, or both, it is recommended efforts be made to include the relevant providers when developing a gender care team. However, this does not mean all disciplines are necessary to provide care to a particular youth and family.

If written documentation or a letter is required to recommend gender-affirming medical and surgical treatment (GAMST) for an adolescent, only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical HCPs and MHPs (American Psychological Association, 2015; Hembree et al., 2017; Telfer et al., 2018). Further assessment results and written opinions may be requested when there is a specific clinical need or when team members are in different locations or choose to write their own summaries. For further information see Chapter 5—Assessment for Adults, Statement 5.5.

#### Statement 6.10

**We recommend health care professionals working with transgender and gender diverse adolescents requesting gender-affirming medical or surgical treatments inform them, prior to the initiation of treatment, of the reproductive effects, including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development.**

While assessing adolescents seeking gender-affirming medical or surgical treatments, HCPs should discuss the specific ways in which the required treatment may affect reproductive capacity. Fertility issues and the specific preservation options are more thoroughly discussed in Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

It is important HCPs understand what fertility preservation options exist so they can relay the information to adolescents. Parents are advised to be involved in this process and should also understand the pros and cons of the different options. HCPs should acknowledge adolescents and parents may have different views around reproductive capacity and may therefore come to different decisions (Quain et al., 2020), which is why HCPs can be helpful in guiding this process.

HCPs should specifically pay attention to the developmental and psychological aspects of fertility preservation and decision-making competency for the individual adolescent. While adolescents may think they have made up their minds concerning their reproductive capacity, the possibility their opinions about having

biologically related children in the future might change over time needs to be discussed with an HCP who has sufficient experience, is knowledgeable about adolescent development, and has experience working with parents.

Addressing the long-term consequences on fertility of gender-affirming medical treatments and ensuring transgender adolescents have realistic expectations concerning fertility preservation options or adoption cannot not be addressed with a one-time discussion but should be part of an ongoing conversation. This conversation should occur not only before initiating any medical intervention (puberty suppression, hormones, or surgeries), but also during further treatment and during transition.

Currently, there are only preliminary results from retrospective studies evaluating transgender adults and the decisions they made when they were young regarding the consequences of medical-affirming treatment on reproductive capacity. It is important not to make assumptions about what future adult goals an adolescent may have. Research in childhood cancer survivors found participants who acknowledged missed opportunities for fertility preservation reported distress and regret surrounding potential infertility (Armuand et al., 2014; Ellis et al., 2016; Lehmann et al., 2017). Furthermore, individuals with cancer who did not prioritize having biological children before treatment have reported “changing their minds” in survivorship (Armuand et al., 2014).

Given the complexities of the different fertility preservation options and the challenges HCPs may experience discussing fertility with the adolescent and the family (Tishelman et al., 2019), a fertility consultation is an important consideration for every transgender adolescent who pursues medical-affirming treatments unless the local situation is such that a fertility consultation is not covered by insurance or public health care plans, is not available locally, or the individual circumstances make this unpreferable.

#### Statement 6.11

**We recommend when gender-affirming medical or surgical treatments are indicated for adolescents, health care professionals working with transgender and gender diverse adolescents**

**involve parent(s)/guardian(s) in the assessment and treatment process, unless their involvement is determined to be harmful to the adolescent or not feasible.**

When there is an indication an adolescent might benefit from a gender-affirming medical or surgical treatment, involving the parent(s) or primary caregiver(s) in the assessment process is recommended in almost all situations (Edwards-Leeper & Spack, 2012; Rafferty et al., 2018). Exceptions to this might include situations in which an adolescent is in foster care, child protective services, or both, and custody and parent involvement would be impossible, inappropriate, or harmful. Parent and family support of TGD youth is a primary predictor of youth well-being and is protective of the mental health of TGD youth (Gower, Rider, Coleman et al., 2018; Grossman et al., 2019; Lefevor et al., 2019; McConnell et al., 2015; Pariseau et al., 2019; Ryan, 2009; Ryan et al., 2010; Simons et al., 2013; Wilson et al., 2016). Therefore, including parent(s)/caregiver(s) in the assessment process to encourage and facilitate increased parental understanding and support of the adolescent may be one of the most helpful practices available.

Parent(s)/caregiver(s) may provide key information for the clinical team, such as the young person's gender and overall developmental, medical, and mental health history as well as insights into the young person's level of current support, general functioning, and well-being. Concordance or divergence of reports given by the adolescent and their parent(s)/caregiver(s) may be important information for the assessment team and can aid in designing and shaping individualized youth and family supports (De Los Reyes et al., 2019; Katz-Wise et al., 2017). Knowledge of the family context, including resilience factors and challenges, can help providers know where special supports would be needed during the medical treatment process. Engagement of parent(s)/caregiver(s) is also important for educating families about various treatment approaches, ongoing follow-up and care needs, and potential treatment complications. Through psychoeducation regarding clinical gender care options and participation in the assessment process, which may unfold over time, parent(s)/caregiver(s) may better understand their adolescent

child's gender-related experience and needs (Andrzejewski et al., 2020; Katz-Wise et al., 2017).

Parent/caregiver concerns or questions regarding the stability of gender-related needs over time and implications of various gender-affirming interventions are common and should not be dismissed. It is appropriate for parent(s)/caregiver(s) to ask these questions, and there are cases in which the parent(s)/caregiver(s)' questions or concerns are particularly helpful in informing treatment decisions and plans. For example, a parent/caregiver report may provide critical context in situations in which a young person experiences very recent or sudden self-awareness of gender diversity and a corresponding gender treatment request, or when there is concern for possible excessive peer and social media influence on a young person's current self-gender concept. Contextualization of the parent/caregiver report is also critical, as the report of a young person's gender history as provided by parent(s)/caregiver(s) may or may not align with the young person's self-report. Importantly, gender histories may be unknown to parent(s)/caregiver(s) because gender may be internal experience for youth, not known by others unless it is discussed. For this reason, an adolescent's report of their gender history and experience is central to the assessment process.

Some parents may present with unsupportive or antagonistic beliefs about TGD identities, clinical gender care, or both (Clark et al., 2020). Such unsupportive perspectives are an important therapeutic target for families. Although challenging parent perspectives may in some cases seem rigid, providers should not assume this is the case. There are many examples of parent(s)/caregiver(s) who, over time with support and psychoeducation, have become increasingly accepting of their TGD child's gender diversity and care needs.

Helping youth and parent(s)/caregiver(s) work together on important gender care decisions is a primary goal. However, in some cases, parent(s)/caregiver(s) may be too rejecting of their adolescent child and their child's gender needs to be part of the clinical evaluation process. In these situations, youth may require the engagement of larger systems of advocacy and support to move

forward with the necessary support and care (Dubin et al., 2020).

#### Statement 6.12

**We recommend health care professionals assessing transgender and gender diverse adolescents only recommend gender-affirming medical or surgical treatments requested by the patient when:**

##### Statement 6.12.a

**The adolescent meets the diagnostic criteria of gender incongruence as per the ICD-11 in situations where a diagnosis is necessary to access health care. In countries that have not implemented the latest ICD, other taxonomies may be used although efforts should be undertaken to utilize the latest ICD as soon as practicable.**

When working with TGD adolescents, HCPs should realize while a classification may give access to care, pathologizing transgender identities may be experienced as stigmatizing (Beek et al., 2016). Assessments related to gender health and gender diversity have been criticized, and controversies exist around diagnostic systems (Drescher, 2016).

HCPs should assess the overall gender-related history and gender care-related needs of youth. Through this assessment process, HCPs may provide a diagnosis when it is required to get access to transgender-related care.

Gender incongruence and gender dysphoria are the two diagnostic terms used in the World Health Organization's International Classification of Diseases (ICD) and the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM), respectively. Of these two widely used classification systems, the DSM is for psychiatric classifications only and the ICD contains all diseases and conditions related to physical as well as mental health. The most recent versions of these two systems, the DSM-5 and the ICD-11, reflect a long history of reconceptualizing and de-psychopathologizing gender-related diagnoses (American Psychiatric Association, 2013; World Health Organization, 2019a). Compared with the earlier version, the DSM-5 replaced gender identity disorder with gender dysphoria, acknowledging the distress experienced by some people stemming from the

incongruence between experienced gender identity and the sex assigned at birth. In the most recent revision, the DSM-5-TR, no changes in the diagnostic criteria for gender dysphoria are made. However, terminology was adapted into the most appropriate current language (e.g., birth-assigned gender instead of natal-gender and gender-affirming treatment instead of gender reassignment (American Psychiatric Association, 2022). Compared with the ICD 10th edition, the gender incongruence classification was moved from the Mental Health chapter to the Conditions Related to Sexual Health chapter in the ICD-11. When compared with the DSM-5 classification of gender dysphoria, one important reconceptualization is distress is not a required indicator of the ICD-11 classification of gender incongruence (WHO, 2019a). After all, when growing up in a supporting and accepting environment, the distress and impairment criterion, an inherent part of every mental health condition, may not be applicable (Drescher, 2012). As such, the ICD-11 classification of gender incongruence may better capture the fullness of gender diversity experiences and related clinical gender needs.

Criteria for the ICD-11 classification gender incongruence of adolescence or adulthood require a marked and persistent incongruence between an individual's experienced gender and the assigned sex, which often leads to a need to "transition" to live and be accepted as a person of the experienced gender. For some, this includes hormonal treatment, surgery, or other health care services to enable the individual's body to align as much as required, and to the extent possible, with the person's experienced gender. Relevant for adolescents is the indicator that a classification cannot be assigned "prior to the onset of puberty." Finally, it is noted "that gender variant behaviour and preferences alone are not a basis for assigning the classification" (WHO, ICD-11, 2019a).

Criteria for the DSM-5 and DSM-5-TR classification of gender dysphoria in adolescence and adulthood denote "a marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration" (criterion A, fulfilled when 2 of 6 subcriteria are manifest; DSM-5, APA, 2013; DSM 5-TR, APA, 2022).

Of note, although a gender-related classification is one of the requirements for receiving medical gender-affirming care, such a classification alone does not indicate a person needs medical-affirming care. The range of youth experiences of gender incongruence necessitates professionals provide a range of treatments or interventions based on the individual's needs. Counseling, gender exploration, mental health assessment and, when needed, treatment with MHPs trained in gender development may all be indicated with or without the implementation of medical-affirming care.

#### Statement 6.12.b

##### **The experience of gender diversity/incongruence is marked and sustained over time.**

Identity exploration and consolidation are experienced by many adolescents (Klimstra et al., 2010; Topolewska-Siedzik & Ciecuch, 2018). Identity exploration during adolescence may include a process of self-discovery around gender and gender identity (Steensma, Kreukels et al., 2013). Little is known about how processes that underlie consolidation of gender identity during adolescence (e.g., the process of commitment to specific identities) may impact a young person's experience(s) or needs over time.

Therefore, the level of reversibility of a gender-affirming medical intervention should be considered along with the sustained duration of a young person's experience of gender incongruence when initiating treatment. Given potential shifts in gender-related experiences and needs during adolescence, it is important to establish the young person has experienced several years of persistent gender diversity/incongruence prior to initiating less reversible treatments such as gender-affirming hormones or surgeries. Puberty suppression treatment, which provides more time for younger adolescents to engage their decision-making capacities, also raises important considerations (see Statement 6.12f and Chapter 12—Hormone Therapy) suggesting the importance of a sustained experience of gender incongruence/diversity prior to initiation. However, in this age group of younger adolescents, several years is not always practical nor necessary given the

premise of the treatment as a means to buy time while avoiding distress from irreversible pubertal changes. For youth who have experienced a shorter duration of gender incongruence, social transition-related and/or other medical supports (e.g., menstrual suppression/androgen blocking) may also provide some relief as well as furnishing additional information to the clinical team regarding a young person's broad gender care needs (see Statements 6.4, 6.6, and 6.7).

Establishing evidence of persistent gender diversity/incongruence typically requires careful assessment with the young person over time (see Statement 6.3). Whenever possible and when appropriate, the assessment and discernment process should also include the parent(s)/caregiver(s) (see Statement 6.11). Evidence demonstrating gender diversity/incongruence sustained over time can be provided via history obtained directly from the adolescent and parents/caregivers when this information is not documented in the medical records.

The research literature on continuity versus discontinuity of gender-affirming medical care needs/requests is complex and somewhat difficult to interpret. A series of studies conducted over the last several decades, including some with methodological challenges (as noted by Temple Newhook et al., 2018; Winters et al., 2018) suggest the experience of gender incongruence is not consistent for all children as they progress into adolescence. For example, a subset of youth who experienced gender incongruence or who socially transitioned prior to puberty over time can show a reduction in or even full discontinuation of gender incongruence (de Vries et al., 2010; Olson et al., 2022; Ristori & Steensma, 2016; Singh et al., 2021; Wagner et al., 2021). However, there has been less research focused on rates of continuity and discontinuity of gender incongruence and gender-related needs in pubertal and adolescent populations. The data available regarding broad unselected gender-referred pubertal/adolescent cohorts (from the Amsterdam transgender clinic) suggest that, following extended assessments over time, a subset of adolescents with gender incongruence presenting for gender care elect not to pursue gender-affirming medical care

(Arnoldussen et al., 2019; de Vries, Steensma et al., 2011). Importantly, findings from studies of gender incongruent pubertal/adolescent cohorts, in which participants who have undergone comprehensive gender evaluation over time, have shown persistent gender incongruence and gender-related need and have received referrals for medical gender care, suggest low levels of regret regarding gender-related medical care decisions (de Vries et al., 2014; Wiepjes et al., 2018). Critically, these findings of low regret can only currently be applied to youth who have demonstrated sustained gender incongruence and gender-related needs over time as established through a comprehensive and iterative assessment (see Statement 6.3).

#### Statement 6.12.c

#### **The adolescent demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment.**

The process of informed consent includes communication between a patient and their provider regarding the patient's understanding of a potential intervention as well as, ultimately, the patient's decision whether to receive the intervention. In most settings, for minors, the legal guardian is integral to the informed consent process: if a treatment is to be given, the legal guardian (often the parent[s]/caregiver[s]) provides the informed consent to do so. In most settings, assent is a somewhat parallel process in which the minor and the provider communicate about the intervention and the provider assesses the level of understanding and intention.

A necessary step in the informed consent/assent process for considering gender-affirming medical care is a careful discussion with qualified HCPs trained to assess the emotional and cognitive maturity of adolescents. The reversible and irreversible effects of the treatment, as well as fertility preservation options (when applicable), and all potential risks and benefits of the intervention are important components of the discussion. These discussions are required when obtaining informed consent/assent. Assessment of cognitive and emotional maturity is important because it helps the care team understand the adolescent's capacity to be informed.

The skills necessary to assent/consent to any medical intervention or treatment include the ability to 1) comprehend the nature of the treatment; 2) reason about treatment options, including the risks and benefits; 3) appreciate the nature of the decision, including the long-term consequences; and 4) communicate choice (Grootens-Wiegers et al., 2017). In the case of gender-affirming medical treatments, a young person should be well-informed about what the treatment may and may not accomplish, typical timelines for changes to appear (e.g., with gender-affirming hormones), and any implications of stopping the treatment. Gender-diverse youth should fully understand the reversible, partially reversible, and irreversible aspects of a treatment, as well as the limits of what is known about certain treatments (e.g., the impact of pubertal suppression on brain development (Chen and Loshak, 2020)). Gender-diverse youth should also understand, although many gender-diverse youth begin gender-affirming medical care and experience that care as a good fit for them long-term, there is a subset of individuals who over time discover this care is not a fit for them (Wiepjes et al., 2018). Youth should know such shifts are sometimes connected to a change in gender needs over time, and in some cases, a shift in gender identity itself. Given this information, gender diverse youth must be able to reason thoughtfully about treatment options, considering the implications of the choices at hand. Furthermore, as a foundation for providing assent, the gender-diverse young person needs to be able to communicate their choice.

The skills needed to accomplish the tasks required for assent/consent may not emerge at specific ages per se (Grootens-Wiegers et al., 2017). There may be variability in these capacities related to developmental differences and mental health presentations (Shumer & Tishelman, 2015) and dependent on the opportunities a young person has had to practice these skills (Alderson, 2007). Further, assessment of emotional and cognitive maturity must be conducted separately for each gender-related treatment decision (Vrouenraets et al., 2021).

The following questions may be useful to consider in assessing a young person's emotional and

cognitive readiness to assent or consent to a specific gender-affirming treatment:

- Can the young person think carefully into the future and consider the implications of a partially or fully irreversible intervention?
- Does the young person have sufficient self-reflective capacity to consider the possibility that gender-related needs and priorities can develop over time, and gender-related priorities at a certain point in time might change?
- Has the young person, to some extent, thought through the implications of what they might do if their priorities around gender do change in the future?
- Is the young person able to understand and manage the day-to-day short- and long-term aspects of a specific medical treatment (e.g., medication adherence, administration, and necessary medical follow-ups)?

Assessment of emotional and cognitive maturity may be accomplished over time as the care team continues to engage in conversations about the treatment options and affords the young person the opportunity to practice thinking into the future and flexibly consider options and implications. For youth with neurodevelopmental and/or some types of mental health differences, skills for future thinking, planning, big picture thinking, and self-reflection may be less-well developed (Dubbeldink & Geurts, 2017). In these cases, a more careful approach to consent and assent may be required, and this may include additional time and structured opportunities for the young person to practice the skills necessary for medical decision-making (Strang, Powers et al., 2018).

For unique situations in which an adolescent minor is consenting for their own treatment without parental permission (see Statement 6.11), extra care must be taken to support the adolescent's informed decision-making. This will typically require greater levels of engagement of and collaboration between the HCPs working with the adolescent to provide the young person appropriate cognitive and emotional support to

consider options, weigh benefits and potential challenges/costs, and develop a plan for any needed (and potentially ongoing) supports associated with the treatment.

Statement 6.12.d

**The adolescent's mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and/or gender-affirming medical treatments have been addressed.**

Evidence indicates TGD adolescents are at increased risk of mental health challenges, often related to family/caregiver rejection, non-affirming community environments, and neurodiversity-related factors (e.g., de Vries et al., 2016; Pariseau et al., 2019; Ryan et al., 2010; Weinhardt et al., 2017). A young person's mental health challenges may impact their conceptualization of their gender development history and gender identity-related needs, the adolescent's capacity to consent, and the ability of the young person to engage in or receive medical treatment. Additionally, like cisgender youth, TGD youth may experience mental health concerns irrespective of the presence of gender dysphoria or gender incongruence. In particular, depression and self-harm may be of specific concern; many studies reveal depression scores and emotional and behavioral problems comparable to those reported in populations referred to mental health clinics (Leibowitz & de Vries, 2016). Higher rates of suicidal ideation, suicide attempts, and self-harm have also been reported (de Graaf et al., 2020). In addition, eating disorders occur more frequently than expected in non-referred populations (Khatchadourian et al., 2013; Ristori et al., 2019; Spack et al., 2012). Importantly, TGD adolescents show high rates of autism spectrum disorder/characteristics (Øien et al., 2018; van der Miesen et al., 2016; see also Statement 6.1d). Other neurodevelopmental presentations and/or mental health challenges may also be present, (e.g., ADHD, intellectual disability, and psychotic disorders (de Vries, Doreleijers et al., 2011; Meijer et al., 2018; Parkes & Hall, 2006).

Of note, many transgender adolescents are well-functioning and experience few if any mental health concerns. For example, socially transitioned pubertal adolescents who receive medical

gender-affirming treatment at specialized gender clinics may experience mental health outcomes equivalent to those of their cisgender peers (e.g., de Vries et al., 2014; van der Miesen et al., 2020). A provider's key task is to assess the direction of the relationships that exist between any mental health challenges and the young person's self-understanding of gender care needs and then prioritize accordingly.

Mental health difficulties may challenge the assessment and treatment of gender-related needs of TGD adolescents in various ways:

1. First, when a TGD adolescent is experiencing acute suicidality, self-harm, eating disorders, or other mental health crises that threaten physical health, safety must be prioritized. According to the local context and existing guidelines, appropriate care should seek to mitigate the threat or crisis so there is sufficient time and stabilization for thoughtful gender-related assessment and decision-making. For example, an actively suicidal adolescent may not be emotionally able to make an informed decision regarding gender-affirming medical/surgical treatment. If indicated, safety-related interventions should not preclude starting gender-affirming care.
2. Second, mental health can also complicate the assessment of gender development and gender identity-related needs. For example, it is critical to differentiate gender incongruence from specific mental health presentations, such as obsessions and compulsions, special interests in autism, rigid thinking, broader identity problems, parent/child interaction difficulties, severe developmental anxieties (e.g., fear of growing up and pubertal changes unrelated to gender identity), trauma, or psychotic thoughts. Mental health challenges that interfere with the clarity of identity development and gender-related decision-making should be prioritized and addressed.
3. Third, decision-making regarding gender-affirming medical treatments that have life-long consequences requires

thoughtful, future-oriented thinking by the adolescent, with support from the parents/caregivers, as indicated (see Statement 6.11). To be able to make such an informed decision, an adolescent should be able to understand the issues, express a choice, appreciate and give careful thought regarding the wish for medical-affirming treatment (see Statement 6.12c). Neurodevelopmental differences, such as autistic features or autism spectrum disorder (see Statement 6.1d, e.g., communication differences; a preference for concrete or rigid thinking; differences in self-awareness, future thinking and planning), may challenge the assessment and decision-making process; neurodivergent youth may require extra support, structure, psychoeducation, and time built into the assessment process (Strang, Powers et al., 2018). Other mental health presentations that involve reduced communication and self-advocacy, difficulty engaging in assessment, memory and concentration difficulties, hopelessness, and difficulty engaging in future-oriented thinking may complicate assessment and decision-making. In such cases, extended time is often necessary before any decisions regarding medical-affirming treatment can be made.

4. Finally, while addressing mental health concerns is important during the course of medical treatment, it does not mean all mental health challenges can or should be resolved completely. However, it is important any mental health concerns are addressed sufficiently so that gender-affirming medical treatment can be provided optimally (e.g., medication adherence, attending follow-up medical appointments, and self-care, particularly during a postoperative course).

Statement 6.12.e

**The adolescent has been informed of the reproductive effects, including the potential loss of fertility, and available options to preserve fertility, and these have been discussed in the context of the adolescent's stage of pubertal development.**

For guidelines regarding the clinical approach, the scientific background, and the rationale, see Chapter 12—Hormone Therapy and Chapter 16—Reproductive Health.

#### Statement 6.12.f

#### **The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated.**

The onset of puberty is a pivotal point for many gender diverse youth. For some, it creates an intensification of their gender incongruence, and for others, pubertal onset may lead to gender fluidity (e.g., a transition from binary to nonbinary gender identity) or even attenuation of a previously affirmed gender identity (Drummond et al., 2008; Steensma et al., 2011, Steensma, Kreukels et al., 2013; Wallien & Cohen-Kettenis, 2008). The use of puberty-blocking medications, such as GnRH analogues, is not recommended until children have achieved a minimum of Tanner stage 2 of puberty because the experience of physical puberty may be critical for further gender identity development for some TGD adolescents (Steensma et al., 2011). Therefore, puberty blockers should not be implemented in prepubertal gender diverse youth (Waal & Cohen-Kettenis, 2006). For some youth, GnRH agonists may be appropriate in late stages or in the post-pubertal period (e.g., Tanner stage 4 or 5), and this should be highly individualized. See Chapter 12—Hormone Therapy for a more comprehensive review of the use of GnRH agonists.

Variations in the timing of pubertal onset is due to multiple factors (e.g., sex assigned at birth, genetics, nutrition, etc.). Tanner staging refers to five stages of pubertal development ranging from prepubertal (Tanner stage 1) to post-pubertal, and adult sexual maturity (Tanner stage 5) (Marshall & Tanner, 1969, 1970). For assigned females at birth, pubertal onset (e.g., gonadarche) is defined by the occurrence of breast budding (Tanner stage 2), and for birth-assigned males, the achievement of a testicular volume of greater than or equal to 4 mL (Roberts & Kaiser, 2020). An experienced medical provider should be relied on to differentiate the onset of puberty from physical changes such as pubic hair and apocrine body odor due to sex steroids produced by the adrenal gland (e.g., adrenarche) as adrenarche

does not warrant the use of puberty-blocking medications (Roberts & Kaiser, 2020). Educating parents and families about the difference between adrenarche and gonadarche helps families understand the timing during which shared decision-making about gender-affirming medical therapies should be undertaken with their multidisciplinary team.

The importance of addressing other risks and benefits of pubertal suppression, both hypothetical and actual, cannot be overstated. Evidence supports the existence of surgical implications for transgender girls who proceed with pubertal suppression (van de Grift et al., 2020). Longitudinal data exists to demonstrate improvement in romantic and sexual satisfaction for adolescents receiving puberty suppression, hormone treatment and surgery (Bungerer et al., 2020). A study on surgical outcomes of laparoscopic intestinal vaginoplasty (performed because of limited genital tissue after the use of puberty blockers) in transgender women revealed that the majority experienced orgasm after surgery (84%), although a specific correlation between sexual pleasure outcomes and the timing of pubertal suppression initiation was not discussed in the study (Bouman, van der Sluis et al., 2016), nor does the study apply to those who would prefer a different surgical procedure. This underscores the importance of engaging in discussions with families about the future unknowns related to surgical and sexual health outcomes.

#### Statement 6.12.g

#### **The adolescent had at least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty, metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated.**

GAHT leads to anatomical, physiological, and psychological changes. The onset of the anatomic effects (e.g., clitoral growth, breast growth, vaginal mucosal atrophy) may begin early after the initiation of therapy, and the peak effect is expected at 1–2 years (T'Sjoen et al., 2019). To

ensure sufficient time for psychological adaptations to the physical change during an important developmental time for the adolescent, 12 months of hormone treatment is suggested. Depending upon the surgical result required, a period of hormone treatment may need to be longer (e.g., sufficient clitoral virilization prior to metoidioplasty/phalloplasty, breast growth and skin expansion prior to breast augmentation, softening of skin and changes in facial fat distribution prior to facial GAS) (de Blok et al., 2021).

For individuals who are not taking hormones prior to surgical interventions, it is important surgeons review the impact of hormone therapy on the proposed surgery. In addition, for individuals undergoing gonadectomy who are not taking hormones, a plan for hormone replacement can be developed with their prescribing professional prior to surgery.

### **Consideration of ages for gender-affirming medical and surgical treatment for adolescents**

Age has a strong, albeit imperfect, correlation with cognitive and psychosocial development and may be a useful objective marker for determining the potential timing of interventions (Ferguson et al., 2021). Higher (i.e., more advanced) ages may be required for treatments with greater irreversibility, complexity, or both. This approach allows for continued cognitive/emotional maturation that may be required for the adolescent to fully consider and consent to increasingly complex treatments (see Statement 6.12c).

A growing body of evidence indicates providing gender-affirming treatment for gender diverse youth who meet criteria leads to positive outcomes (Achille et al., 2020; de Vries et al., 2014; Kuper et al., 2020). There is, however, limited data on the optimal timing of gender-affirming interventions as well as the long-term physical, psychological, and neurodevelopmental outcomes in youth (Chen et al., 2020; Chew et al., 2018; Olson-Kennedy et al., 2016). Currently, the only existing longitudinal studies evaluating gender diverse youth and adult outcomes are based on a specific model (i.e., the Dutch approach) that involved a comprehensive initial assessment with follow-up. In this approach, pubertal suppression was considered at age 12, GAHT at age 16, and

surgical interventions after age 18 with exceptions in some cases. It is not clear if deviations from this approach would lead to the same or different outcomes. Longitudinal studies are currently underway to better define outcomes as well as the safety and efficacy of gender-affirming treatments in youth (Olson-Kennedy, Garofalo et al., 2019; Olson-Kennedy, Rosenthal et al., 2019). While the long-term effects of gender-affirming treatments initiated in adolescence are not fully known, the potential negative health consequences of delaying treatment should also be considered (de Vries et al., 2021). As the evidence base regarding outcomes of gender-affirming interventions in youth continues to grow, recommendations on the timing and readiness for these interventions may be updated.

Previous guidelines regarding gender-affirming treatment of adolescents recommended partially reversible GAHT could be initiated at approximately 16 years of age (Coleman et al., 2012; Hembree et al., 2009). More recent guidelines suggest there may be compelling reasons to initiate GAHT prior to the age of 16, although there are limited studies on youth who have initiated hormones prior to 14 years of age (Hembree et al., 2017). A compelling reason for earlier initiation of GAHT, for example, might be to avoid prolonged pubertal suppression, given potential bone health concerns and the psychosocial implications of delaying puberty as described in more detail in Chapter 12—Hormone Therapy (Klink, Caris et al., 2015; Schagen et al., 2020; Vlot et al., 2017; Zhu & Chan, 2017). Puberty is a time of significant brain and cognitive development. The potential neurodevelopmental impact of extended pubertal suppression in gender diverse youth has been specifically identified as an area in need of continued study (Chen et al., 2020). While GnRH analogs have been shown to be safe when used for the treatment of precocious puberty, there are concerns delaying exposure to sex hormones (endogenous or exogenous) at a time of peak bone mineralization may lead to decreased bone mineral density. The potential decrease in bone mineral density as well as the clinical significance of any decrease requires continued study (Klink, Caris et al., 2015; Lee, Finlayson et al.,

2020; Schagen et al., 2020). The potential negative psychosocial implications of not initiating puberty with peers may place additional stress on gender diverse youth, although this has not been explicitly studied. When considering the timing of initiation of gender-affirming hormones, providers should compare the potential physical and psychological benefits and risks of starting treatment with the potential risks and benefits of delaying treatment. This process can also help identify compelling factors that may warrant an individualized approach.

Studies carried out with trans masculine youth have demonstrated chest dysphoria is associated with higher rates of anxiety, depression, and distress and can lead to functional limitations, such as avoiding exercising or bathing (Mehringer et al., 2021; Olson-Kennedy, Warus et al., 2018; Sood et al., 2021). Testosterone unfortunately does little to alleviate this distress, although chest masculinization is an option for some individuals to address this distress long-term. Studies with youth who sought chest masculinization surgery to alleviate chest dysphoria demonstrated good surgical outcomes, satisfaction with results, and minimal regret during the study monitoring period (Marinkovic & Newfield, 2017; Olson-Kennedy, Warus et al., 2018). Chest masculinization surgery can be considered in minors when clinically and developmentally appropriate as determined by a multidisciplinary team experienced in adolescent and gender development (see relevant statements in this chapter). The duration or current use of testosterone therapy should not preclude surgery if otherwise indicated. The needs of some TGD youth may be met by chest masculinization surgery alone. Breast augmentation may be needed by trans feminine youth, although there is less data about this procedure in youth, possibly due to fewer individuals requesting this procedure (Boskey et al., 2019; James, 2016). GAHT, specifically estrogen, can help with development of breast tissue, and it is recommended youth have a minimum of 12 months of hormone therapy, or longer as is surgically indicated, prior to breast augmentation unless hormone therapy is not clinically indicated or is medically contraindicated.

Data are limited on the optimal timing for initiating other gender-affirming surgical treatments in adolescents. This is partly due to the limited access to these treatments, which varies in different geographical locations (Mahfouda et al., 2019). Data indicate rates of gender-affirming surgeries have increased since 2000, and there has been an increase in the number of TGD youth seeking vaginoplasty (Mahfouda et al., 2019; Milrod & Karasic, 2017). A 2017 study of 20 WPATH-affiliated surgeons in the US reported slightly more than half had performed vaginoplasty in minors (Milrod & Karasic, 2017). Limited data are available on the outcomes for youth undergoing vaginoplasty. Small studies have reported improved psychosocial functioning and decreased gender dysphoria in adolescents who have undergone vaginoplasty (Becker et al., 2018; Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001). While the sample sizes are small, these studies suggest there may be a benefit for some adolescents to having these procedures performed before the age of 18. Factors that may support pursuing these procedures for youth under 18 years of age include the increased availability of support from family members, greater ease of managing postoperative care prior to transitioning to tasks of early adulthood (e.g., entering university or the workforce), and safety concerns in public spaces (i.e., to reduce transphobic violence) (Boskey et al., 2018; Boskey et al., 2019; Mahfouda et al., 2019). Given the complexity and irreversibility of these procedures, an assessment of the adolescent's ability to adhere to post-surgical care recommendations and to comprehend the long-term impacts of these procedures on reproductive and sexual function is crucial (Boskey et al., 2019). Given the complexity of phalloplasty, and current high rates of complications in comparison to other gender-affirming surgical treatments, it is not recommended this surgery be considered in youth under 18 at this time (see Chapter 13—Surgery and Postoperative Care).

Additional key factors that should be taken into consideration when discussing the timing of interventions with youth and families are addressed in detail in statements 6.12a-f. For a summary of the criteria/recommendations for medically necessary gender-affirming medical treatment in adolescents, see [Appendix D](#).

## CHAPTER 7 Children

These Standards of Care pertain to prepubescent gender diverse children and are based on research, ethical principles, and accumulated expert knowledge. The principles underlying these standards include the following 1) childhood gender diversity is an expected aspect of general human development (Endocrine Society and Pediatric Endocrine Society, 2020; Telfer et al., 2018); 2) childhood gender diversity is not a pathology or mental health disorder (Endocrine Society and Pediatric Endocrine Society, 2020; Oliphant et al., 2018; Telfer et al., 2018); 3) diverse gender expressions in children cannot always be assumed to reflect a transgender identity or gender incongruence (Ehrensaft, 2016; Ehrensaft, 2018; Rael et al., 2019); 4) guidance from mental health professionals (MHPs) with expertise in gender care for children can be helpful in supporting positive adaptation as well as discernment of gender-related needs over time (APA, 2015; Ehrensaft, 2018; Telfer et al., 2018); 5) conversion therapies for gender diversity in children (i.e., any “therapeutic” attempts to compel a gender diverse child through words, actions, or both to identify with, or behave in accordance with, the gender associated with the sex assigned at birth are harmful and we repudiate their use (APA, 2021; Ashley, 2019b, Paré, 2020; SAMHSA, 2015; Telfer et al., 2018; UN Human Rights Council, 2020).

Throughout the text, the term “health care professional” (HCP) is used broadly to refer to professionals working with gender diverse children. Unlike pubescent youth and adults, prepubescent gender diverse children are not eligible to access medical intervention (Pediatric Endocrine Society, 2020); therefore, when professional input is sought, it is most likely to be from an HCP specialized in psychosocial supports and gender development. Thus, this chapter is uniquely focused on developmentally appropriate psychosocial practices, although other HCPs, such as pediatricians and family practice HCPs may also find these standards useful as they engage in professional work with gender diverse children and their families.

This chapter employs the term “gender diverse” given that gender trajectories in prepubescent

children cannot be predicted and may evolve over time (Steensma, Kreukels et al., 2013). At the same time, this chapter recognizes some children will remain stable in a gender identity they articulate early in life that is discrepant from the sex assigned at birth (Olson et al., 2022). The term, “gender diverse” includes transgender binary and nonbinary children, as well as gender diverse children who will ultimately not identify as transgender later in life. Terminology is inherently culturally bound and evolves over time. Thus, it is possible terms used here may become outdated and we will find better descriptors.

This chapter describes aspects of medical necessary care intended to promote the well-being and gender-related needs of children (see medically necessary statement in the Global Applicability chapter, Statement 2.1). This chapter advocates everyone employs these standards, to the extent possible. There may be situations or locations in which the recommended resources are not fully available. HCPs/teams lacking resources need to work toward meeting these standards. However, if unavoidable limitations preclude components of these recommendations, this should not hinder providing the best services currently available. In those locations where some but not all recommended services exist, choosing not to implement potentially beneficial care services risks harm to a child (Murchison et al., 2016; Telfer et al., 2018; Riggs et al., 2020). Overall, it is imperative to prioritize a child’s best interests.

A vast empirical psychological literature indicates early childhood experiences frequently set the stage for lifelong patterns of risk and/or resilience and contribute to a trajectory of development more or less conducive to well-being and a positive quality of life (Anda et al., 2010; Masten & Cicchetti, 2010; Shonkoff & Garner, 2012). The available research indicates, in general, gender diverse youth are at greater risk for experiencing psychological difficulties (Ristori & Steensma, 2016) than age-matched cisgender peers as a result of encountering destructive experiences, including trauma and maltreatment stemming from gender diversity-related rejection and other harsh, non-accepting interactions (Barrow & Apostle, 2018; Giovanardi et al., 2018; Gower, Rider, Brown et al., 2018; Grossman & D’Augelli, 2006; Hendricks & Testa, 2012; Reisner, Greytak

et al., 2015; Roberts et al., 2014; Tishelman & Neumann-Mascis, 2018). Further, literature indicates prepubescent children who are well accepted in their gender diverse identities are generally well-adjusted (Malpas et al., 2018; Olson et al., 2016). Assessment and treatment of children typically emphasizes an *ecological* approach, recognizing children need to be safe and nurtured in each setting they frequent (Belsky, 1993; Bronfenbrenner, 1979; Kaufman & Tishelman, 2018; Lynch & Cicchetti, 1998; Tishelman et al., 2010; Zielinski & Bradshaw, 2006). Thus, the perspective of this chapter draws on basic psychological literature and knowledge of the unique risks to gender diverse children and emphasizes the integration of an ecological approach to understanding their needs and to facilitating positive mental health in all gender care. This perspective prioritizes fostering well-being and quality of life for a child throughout their development. Additionally, this chapter also embraces the viewpoint, supported by the substantial psychological research cited above, that psychosocial gender-affirming care (Hidalgo et al., 2013) for prepubescent children offers a window of opportunity to promote a trajectory of well-being that will sustain them over time and during the transition to adolescence. This approach potentially can mitigate some of the common mental health risks faced by transgender and gender diverse (TGD) teens, as frequently described in literature (Chen et al., 2021; Edwards-Leeper et al., 2017; Haas et al., 2011; Leibowitz & de Vries, 2016; Reisner, Bradford et al., 2015; Reisner, Greytak et al., 2015).

Developmental research has focused on understanding various aspects of gender development in the earliest years of childhood based on a general population of prepubescent children. This research has typically relied on the assumption that child research participants are cisgender (Olezeski et al., 2020) and has reported gender identity stability is established in the preschool years for the general population of children, most of whom are likely not gender diverse (Kohlberg, 1966; Steensma, Kreukels et al., 2013). Recently, developmental research has demonstrated gender diversity can be observed and identified in young prepubescent children (Fast & Olson, 2018; Olson & Gülgöz, 2018; Robles et al., 2016). Nonetheless, empirical

study in this area is limited, and at this time there are no psychometrically sound assessment measures capable of reliably and/or fully ascertaining a prepubescent child's self-understanding of their own gender and/or gender-related needs and preferences (Bloom et al., 2021). Therefore, this chapter emphasizes the importance of a nuanced and individualized clinical approach to gender assessment, consistent with the recommendations from various guidelines and literature (Berg & Edwards-Leeper, 2018; de Vries & Cohen-Kettenis, 2012; Ehrensaft, 2018; Steensma & Wensing-Kruger, 2019). Research and clinical experience have indicated gender diversity in prepubescent children may, for some, be fluid; there are no reliable means of predicting an individual child's gender evolution (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013), and the gender-related needs for a particular child may vary over the course of their childhood.

It is important to understand the meaning of the term "assessment" (sometimes used synonymously with the term "evaluation"). There are multiple contexts for assessment (Krishnamurthy et al., 2004) including rapid assessments that take place during an immediate crisis (e.g., safety assessment when a child may be suicidal) and focused assessments when a family may have a circumscribed question, often in the context of a relatively brief consultation (Berg & Edwards-Leeper, 2018). The term assessment is also often used in reference to "diagnostic assessment," which can also be called an "intake" and is for the purpose of determining whether there is an issue that is diagnosable and/or could benefit from a therapeutic process. This chapter focus on comprehensive assessments, useful for understanding a child and family's needs and goals (APA, 2015; de Vries & Cohen-Kettenis, 2012; Srinath et al., 2019; Steensma & Wensing-Kruger, 2019). This type of psychosocial assessment is not necessary for all gender diverse children, but may be requested for a number of reasons. Assessments may present a useful opportunity to start a process of support for a gender diverse child and their family, with the understanding that gender diverse children benefit when their family dynamics include

**Statements of Recommendations**

- 7.1- We recommend health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess a general knowledge of gender diversity across the life span.
- 7.2- We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.
- 7.3- We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.
- 7.4- We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.
- 7.5- We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.
- 7.6- We recommend health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning, and language skills.
- 7.7- We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).
- 7.8- We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.
- 7.9- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.
- 7.10- We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age-appropriate psychoeducation about gender development.
- 7.11- We recommend that health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.
- 7.12- We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.
- 7.13- We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.
- 7.14- We recommend the health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.
- 7.15- We suggest health care professionals consider working collaboratively with other professionals and organizations to promote the well-being of gender diverse children and minimize the adversities they may face.

acceptance of their gender diversity and parenting guidance when requested. Comprehensive assessments are appropriate when solicited by a family requesting a full understanding of the child's gender and mental health needs in the context of gender diversity.

In these circumstances, family member mental health issues, family dynamics, and social and cultural contexts, all of which impact a gender diverse child, should be taken into consideration (Barrow & Apostle, 2018; Brown & Mar, 2018; Cohen-Kettenis et al., 2003; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Ristori & Steensma, 2016; Tishelman & Neumann-Mascis, 2018). This is further elaborated upon in the text below.

It is important HCPs working with gender diverse children strive to understand the child and the family's various aspects of identity and experience: racial, ethnic, immigrant/refugee status, religious, geographic, and socio-economic, for example, and be respectful and sensitive to cultural

context in clinical interactions (Telfer et al., 2018). Many factors may be relevant to culture and gender, including religious beliefs, gender-related expectations, and the degree to which gender diversity is accepted (Oliphant et al., 2018). Intersections between gender diversity, sociocultural diversity, and minority statuses can be sources of strength, social stress, or both (Brown & Mar, 2018; Oliphant et al., 2018; Riggs & Treharne, 2016).

Each child, family member, and family dynamic is unique and potentially encompasses multiple cultures and belief patterns. Thus, HCPs of all disciplines should avoid stereotyping based on preconceived ideas that may be incorrect or biased (e.g., that a family who belongs to a religious organization that is opposed to appreciating gender diversity will necessarily be unsupportive of their child's gender diversity) (Brown & Mar, 2018). Instead, it is essential to approach each family openly and understand each family member and family pattern as distinct.

All the statements in this chapter have been recommended based on a thorough review of evidence, an assessment of the benefits and harms, values and preferences of providers and patients, and resource use and feasibility. In some cases, we recognize evidence is limited and/or services may not be accessible or desirable.

#### Statement 7.1

**We recommend the health care professionals working with gender diverse children receive training and have expertise in gender development and gender diversity in children and possess general knowledge of gender diversity across the life span.**

HCPs working with gender diverse children should acquire and maintain the necessary training and credentials relevant to the scope of their role as professionals. This includes licensure, certification, or both by appropriate national and/or regional accrediting bodies. We recognize the specifics of credentialing and regulation of professionals vary globally. Importantly, basic licensure, certification, or both may be insufficient in and of itself to ensure competency working with gender diverse children, as HCPs specifically require in-depth training and supervised experience in childhood gender development and gender diversity to provide appropriate care.

#### Statement 7.2

**We recommend health care professionals working with gender diverse children receive theoretical and evidenced-based training and develop expertise in general child and family mental health across the developmental spectrum.**

HCPs should receive training and supervised expertise in general child and family mental health across the developmental spectrum from toddlerhood through adolescence, including evidence-based assessment and intervention approaches. Gender diversity is not a mental health disorder; however, as cited above, we know mental health can be adversely impacted for gender diverse children (e.g., through gender minority stress) (Hendricks & Testa, 2012) that may benefit from exploration and support; therefore, mental health expertise is highly recommended. Working with children is a complex endeavor, involving

an understanding of a child's developmental needs at various ages, the ability to comprehend the forces impacting a child's well-being both inside and outside the family (Kaufman & Tishelman, 2018), and an ability to fully assess when a child is unhappy or experiencing significant mental health difficulties, related or unrelated to gender. Research has indicated high levels of adverse experiences and trauma in the gender diverse community of children, including susceptibility to rejection or even maltreatment (APA, 2015; Barrow & Apostle, 2018; Giovanardi et al., 2018; Reisner, Greytak et al., 2015; Roberts et al., 2012; Tishelman & Neumann-Mascis, 2018). HCPs need to be cognizant of the potential for adverse experiences and be able to initiate effective interventions to prevent harm and promote positive well-being.

#### Statement 7.3

**We recommend health care professionals working with gender diverse children receive training and develop expertise in autism spectrum disorders and other neurodiversity or collaborate with an expert with relevant expertise when working with autistic/neurodivergent, gender diverse children.**

The experience of gender diversity in autistic children as well as in children with other forms of neurodivergence may present extra clinical complexities (de Vries et al., 2010; Strang, Meagher et al., 2018). For example, autistic children may find it difficult to self-advocate for their gender-related needs and may communicate in highly individualistic ways (Kupalanka et al., 2018; Strang, Powers et al., 2018). They may have varied interpretations of gender-related experiences given common differences in communication and thinking style. Because of the unique needs of gender diverse neurodivergent children, they may be at high risk for being misunderstood (i.e., for their communications to be misinterpreted). Therefore, professionals providing support to these children can best serve them by receiving training and developing expertise in autism and related neurodevelopmental presentations and/or collaborating with autism specialists (Strang, Meagher et al., 2018). Such training is especially relevant as research has documented

higher rates of autism among gender diverse youth than in the general population (de Vries et al., 2010; Hisle-Gorman et al., 2019; Shumer et al., 2015).

#### Statement 7.4

**We recommend health care professionals working with gender diverse children engage in continuing education related to gender diverse children and families.**

Continuing professional development regarding gender diverse children and families may be acquired through various means, including through readings (journal articles, books, websites associated with gender knowledgeable organizations), attending on-line and in person trainings, and joining peer supervision/consultation groups (Bartholomaeus et al., 2021).

Continuing education includes 1) maintaining up-to-date knowledge of available and relevant research on gender development and gender diversity in prepubescent children and gender diversity across the life span; 2) maintaining current knowledge regarding best practices for assessment, support, and treatment approaches with gender diverse children and families. This is a relatively new area of practice and health care professionals need to adapt as new information emerges through research and other avenues (Bartholomaeus et al., 2021).

#### Statement 7.5

**We recommend health care professionals conducting an assessment with gender diverse children access and integrate information from multiple sources as part of the assessment.**

A comprehensive assessment, when requested by a family and/or an HCP can be useful for developing intervention recommendations, as needed, to benefit the well-being of the child and other family members. Such an assessment can be beneficial in a variety of situations when a child and/or their family/guardians, in coordination with providers, feel some type of intervention would be helpful. Neither assessments nor interventions should ever be used as a means of covertly or overtly discouraging a child's gender diverse expressions or identity. Instead, with appropriately trained providers, assessment can be an effective

means of better understanding how to support a child and their family without privileging any particular gender identity or expression. An assessment can be especially important for some children and their families by collaborating to promote a child's gender health, well-being, and self-fulfillment.

A comprehensive assessment can facilitate the formation of an individualized plan to assist a gender diverse prepubescent children and family members (de Vries & Cohen-Kettenis, 2012; Malpas et al., 2018; Steensma & Wensing-Kruger, 2019; Telfer et al., 2018; Tishelman & Kaufman, 2018). In such an assessment, integrating information from multiple sources is important to 1) best understand the child's gender needs and make recommendations; and 2) identify areas of child, family/caregiver, and community strengths and supports specific to the child's gender status and development as well as risks and concerns for the child, their family/caregivers and environment. Multiple informants for both evaluation and support/intervention planning purposes may include the child, parents/caregivers, extended family members, siblings, school personnel, HCPs, the community, broader cultural and legal contexts and other sources as indicated (Berg & Edwards-Leeper, 2018; Srinath, 2019).

An HCP conducting an assessment of gender diverse children needs to explore gender-related issues but must also take a broad view of the child and the environment, consistent with the ecological model described above (Bronfenbrenner, 1979) to fully understand the factors impacting a child's well-being and areas of gender support and risk (Berg & Edwards-Leeper, 2018; Hendricks & Testa, 2012; Kaufman & Tishelman, 2018; Tishelman & Neumann-Mascis, 2018). This includes understanding the strengths and challenges experienced by the child/family and that are present in the environment. We advise HCPs conducting an assessment with gender diverse children to consider incorporating multiple assessment domains, depending on the child and the family's needs and circumstances. Although some of the latter listed domains below do not directly address the child's gender (see items 7–12 below), they need to be accounted for in a gender assessment, as indicated by clinical judgment, to understand the complex web of factors

that may be affecting the child's well-being in an integrated fashion, including gender health, consistent with evaluation best practices a (APA, 2015; Berg & Edwards-Leeper, 2018; Malpas et al., 2018) and develop a multi-pronged intervention when needed.

Summarizing from relevant research and clinical expertise, assessment domains often include 1) a child's asserted gender identity and gender expression, currently and historically; 2) evidence of dysphoria, gender incongruence, or both; 3) strengths and challenges related to the child, family, peer and others' beliefs and attitudes about gender diversity, acceptance and support for child; 4) child and family experiences of gender minority stress and rejection, hostility, or both due to the child's gender diversity; 5) level of support related to gender diversity in social contexts (e.g., school, faith community, extended family); 6) evaluation of conflict regarding the child's gender and/or parental/caregiver/sibling concerning behavior related to the child's gender diversity; 7) child mental health, communication and/or cognitive strengths and challenges, neurodivergence, and/or behavioral challenges causing significant functional difficulty; 8) relevant medical and developmental history; 9) areas that may pose risks (e.g., exposure to domestic and/or community violence, any form of child maltreatment; history of trauma; safety and/or victimization with peers or in any other setting; suicidality); 10) co-occurring significant family stressors, such as chronic or terminal illness, homelessness or poverty; 11) parent/caregiver and/or sibling mental health and/or behavioral challenges causing significant functional difficulty; and 12) child's and family's strengths and challenges.

A thorough assessment incorporating multiple forms of information gathering is helpful for understanding the needs, strengths, protective factors, and risks for a specific child and family across environments (e.g., home/school). Methods of information gathering often include 1) interviews with the child, family members and others (e.g., teachers), structured and unstructured; 2) caregiver and child completed standardized measures related to gender; general child well-being; child cognitive and communication skills and developmental disorders/disabilities; support and acceptance by parent/caregiver, sibling, extended

family and peers; parental stress; history of childhood adversities; and/or other issues as appropriate (APA, 2020; Berg & Edwards-Leeper, 2018; Kaufman & Tishelman, 2018; Srinath, 2019).

Depending on the family characteristics, the developmental profile of the child, or both, methods of information gathering also may also benefit from including the following 1) child and/or family observation, structured and unstructured; and 2) structured and visually supported assessment techniques (worksheets; self-portraits; family drawings, etc.) (Berg & Edwards-Leeper, 2018).

#### Statement 7.6

**We recommend that health care professionals conducting an assessment with gender diverse children consider relevant developmental factors, neurocognitive functioning and language skills.**

Given the complexities of assessing young children who, unlike adults, are in the process of development across a range of domains (cognitive, social, emotional, physiological), it is important to consider the developmental status of a child and gear assessment modalities and interactions to the individualized abilities of the child. This includes tailoring the assessment to a child's developmental stage and abilities (preschoolers, school age, early puberty prior to adolescence), including using language and assessment approaches that prioritize a child's comfort, language skills, and means of self-expression (Berg & Edwards-Leeper, 2018; Srinath, 2019). For example, relevant developmental factors, such as neurocognitive differences (e.g., autism spectrum conditions), and receptive and expressive language skills should be considered in conducting the assessment. Health care professionals may need to consult with specialists for guidance in cases in which they do not possess the specialized skills themselves (Strang et al., 2021).

#### Statement 7.7

**We recommend health care professionals conducting an assessment with gender diverse children consider factors that may constrain accurate reporting of gender identity/gender expression by the child and/or family/caregiver(s).**

HCPs conducting an assessment with gender diverse children and families need to account for developmental, emotional, and environmental factors that may constrain a child's, caregiver's, sibling or other's report or influence their belief systems related to gender (Riggs & Bartholomaeus, 2018). As with all child psychological assessments, environmental and family/caregiver reactions (e.g., punishment), and/or cognitive and social factors may influence a child's comfort and/or ability to directly discuss certain factors, including gender identity and related issues (Srinath, 2019). Similarly, family members may feel constrained in freely expressing their concerns and ideas depending on family conflicts or dynamics and/or other influences (e.g., cultural/religious; extended family pressure) (Riggs & Bartholomaeus, 2018).

#### Statement 7.8

**We recommend health care professionals consider consultation, psychotherapy, or both for a gender diverse child and family/caregivers when families and health care professionals believe this would benefit the well-being and development of a child and/or family.**

The goal of psychotherapy should never be aimed at modifying a child's gender identity (APA, 2021; Ashley, 2019b; Paré, 2020; SAMHSA, 2015; UN Human Rights Council, 2020), either covertly or overtly. Not all gender diverse children or their families need input from MHPs as gender diversity is not a mental health disorder (Pediatric Endocrine Society, 2020; Telfer et al., 2018). Nevertheless, it is often appropriate and helpful to seek psychotherapy when there is distress or concerns are expressed by parents to improve psychosocial health and prevent further distress (APA, 2015). Some of the common reasons for considering psychotherapy for a gender diverse child and family include the following 1) A child is demonstrating significant conflicts, confusion, stress or distress about their gender identity or needs a protected space to explore their gender (Ehrensaft, 2018; Spivey and Edwards-Leeper, 2019); 2) A child is experiencing external pressure to express their gender in a way that conflicts with their self-knowledge, desires, and beliefs (APA, 2015); 3) A child is struggling with mental health concerns, related to or independent of their gender

(Barrow & Apostle, 2018); 4) A child would benefit from strengthening their resilience in the face of negative environmental responses to their gender identity or presentation (Craig & Auston, 2018; Malpas et al., 2018); 5) A child may be experiencing mental health and/or environmental concerns, including family system problems that can be misinterpreted as gender congruence or incongruence (Berg & Edwards-Leeper, 2018); and 6) A child expresses a desire to meet with an MHP to get gender-related support. In these situations, the psychotherapy will focus on supporting the child with the understanding that the child's parent(s)/caregiver(s) and potentially other family members will be included as necessary (APA, 2015; Ehrensaft, 2018; McLaughlin & Sharp, 2018). Unless contraindicated, it is extremely helpful for parents/guardians to participate in some capacity in the psychotherapy process involving prepubescent children as family factors are often central to a child's well-being. Although relatively unexplored in research involving gender diverse children, it may be important to attend to the relationship between siblings and the gender diverse child (Pariseau et al., 2019; Parker & Davis-McCabe, 2021).

HCPs should employ interventions tailor-made to the individual needs of the child that are designed to 1) foster protective social and emotional coping skills to promote resilience in the face of potential negative reactions to the child's gender identity, expressions, or both (Craig & Austin, 2016; Malpas et al., 2018; Spencer, Berg et al., 2021); 2) collaboratively problem-solve social challenges to reduce gender minority stress (Barrow & Apostle, 2018; Tishelman & Neumann-Mascis, 2018); 3) strengthen environmental supports for the child and/or members of the immediate and extended family (Kaufman & Tishelman, 2018); and 4) provide the child an opportunity to further understand their internal gender experiences (APA, 2015; Barrow & Apostle, 2018; Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). It is helpful for HCPs to develop a relationship with a gender diverse child and family that can endure over time as needed. This enables the child/family to establish a long-term trusting relationship throughout childhood whereby the HCP can offer support and guidance as a child matures and as potentially

different challenges or needs emerge for the child/family (Spencer, Berg et al., 2021; Murchison et al., 2016). In addition to the above and within the limits of available resources, when a child is neurodivergent, an HCP who has the skill set to address both neurodevelopmental differences and gender is most appropriate (Strang et al., 2021).

As outlined in the literature, there are numerous reasons parents/caregivers, siblings, and extended family members of a prepubescent child may find it useful to seek psychotherapy for themselves (Ehrensaft, 2018; Malpas et al., 2018; McLaughlin & Sharp, 2018). As summarized below, some of these common catalysts for seeking such treatment occur when one or more *family members* 1) desire education around gender development (Spivey & Edwards-Leeper, 2019); 2) are experiencing significant confusion or stress about the child's gender identity, expression, or both (Ashley, 2019c; Ehrensaft, 2018); 3) need guidance related to emotional and behavioral concerns regarding the gender diverse child (Barrow & Apostle, 2018; 4) need support to promote affirming environments outside of the home (e.g., school, sports, camps) (Kaufman & Tishelman, 2018); 5) are seeking assistance to make informed decisions about social transition, including how to do so in a way that is optimal for a child's gender development and health (Lev & Wolf-Gould, 2018); 6) are seeking guidance for dealing with condemnation from others, including political entities and accompanying legislation, regarding their support for their gender diverse child (negative reactions directed toward parents/caregivers can sometimes include rejection and/or harassment/abuse from the social environment arising from affirming decisions (Hidalgo & Chen, 2019); 7) are seeking to process their own emotional reactions and needs about their child's gender identity, including grief about their child's gender diversity and/or potential fears or anxieties for their child's current and future well-being (Pullen Sansfaçon et al., 2019); and 8) are emotionally distressed and/or in conflict with other family members regarding the child's gender diversity (as needed, HCPs can provide separate sessions for parents/caregivers, siblings and extended family members for support, guidance, and/or psychoeducation)

(McLaughlin & Sharp, 2018; Pullen Sansfaçon et al., 2019; Spivey & Edwards-Leeper, 2019).

#### Statement 7.9

**We recommend health care professionals offering consultation, psychotherapy, or both to gender diverse children and families/caregivers work with other settings and individuals important to the child to promote the child's resilience and emotional well-being.**

Consistent with the ecological model described above and, as appropriate, based on individual/family circumstances, it can be extremely helpful for HCPs to prioritize coordination with important others (e.g., teachers, coaches, religious leaders) in a child's life to promote emotional and physical safety across settings (e.g., school settings, sports and other recreational activities, faith-based involvement) (Kaufman & Tishelman, 2018). Therapeutic and/or support groups are often recommended as a valuable resource for families/caregivers and/or gender diverse children themselves (Coolhart, 2018; Horton et al., 2021; Malpas et al., 2018; Murchison et al., 2016).

#### Statement 7.10

**We recommend HCPs offering consultation, psychotherapy, or both to gender diverse children and families/caregivers provide both parties with age appropriate psycho-education about gender development.**

Parents/caregivers and their gender diverse child should have the opportunity to develop knowledge regarding ways in which families/caregivers can best support their child to maximize resilience, self-awareness, and functioning (APA, 2015; Ehrensaft, 2018; Malpas, 2018; Spivey & Edwards-Leeper, 2019). It is neither possible nor is it the role of the HCP to predict with certainty the child's ultimate gender identity; instead, the HCP's task is to provide a safe space for the child's identity to develop and evolve over time without attempts to prioritize any particular developmental trajectory with regard to gender (APA, 2015; Spivey & Edwards-Leeper, 2019). Gender diverse children and early adolescents have different needs and experiences than older adolescents, socially and physiologically, and those differences should be reflected in the individualized approach HCPs

provide to each child/family (Keo-Meir & Ehrensaft, 2018; Spencer, Berg et al., 2021).

Parents/caregivers and their children should also have the opportunity to develop knowledge about gender development and gender literacy through age-appropriate psychoeducation (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy involves understanding the distinctions between sex designated at birth, gender identity, and gender expression, including the ways in which these three factors uniquely come together for a child (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). As a child gains gender literacy, they begin to understand their body parts do not necessarily define their gender identity and/or their gender expression (Berg & Edwards-Leeper, 2018; Rider, Vencill et al., 2019; Spencer, Berg et al., 2021). Gender literacy also involves learning to identify messages and experiences related to gender within society. As a child gains gender literacy, they may view their developing gender identity and gender expression more positively, promoting resilience and self-esteem, and diminishing risk of shame in the face of negative messages from the environment. Gaining gender literacy through psychoeducation may also be important for siblings and/or extended family members who are important to the child (Rider, Vencill et al., 2019; Spencer, Berg et al., 2021).

#### Statement 7.11

**We recommend health care professionals provide information to gender diverse children and their families/caregivers as the child approaches puberty about potential gender-affirming medical interventions, the effects of these treatments on future fertility, and options for fertility preservation.**

As a child matures and approaches puberty, HCPs should prioritize working with children and their parents/caregivers to integrate psychoeducation about puberty, engage in shared decision-making about potential gender-affirming medical interventions, and discuss fertility-related and other reproductive health implications of medical treatments (Nahata, Quinn et al., 2018; Spencer, Berg et al., 2021). Although only limited

empirical research exists to evaluate such interventions, expert consensus and developmental psychological literature generally support the notion that open communication with children about their bodies and preparation for physiological changes of puberty, combined with gender-affirming acceptance, will promote resilience and help to foster positive sexuality as a child matures into adolescence (Spencer, Berg et al., 2019). All these discussions may be extended (e.g., starting earlier) to include neurodivergent children, to ensure there is enough time for reflection and understanding, especially as choices regarding future gender-affirming medical care potentially arise (Strang, Jarin et al., 2018). These discussions could include the following topics:

- Review of body parts and their different functions;
- The ways in which a child's body may change over time with and without medical intervention;
- The impact of medical interventions on later sexual functioning and fertility;
- The impact of puberty suppression on potential later medical interventions;
- Acknowledgment of the current lack of clinical data in certain areas related to the impacts of puberty suppression;
- The importance of appropriate sex education prior to puberty.

These discussions should employ developmentally appropriate language and teaching styles, and be geared to the specific needs of each individual child (Spencer, Berg et al., 2021).

#### Statement 7.12

**We recommend parents/caregivers and health care professionals respond supportively to children who desire to be acknowledged as the gender that matches their internal sense of gender identity.**

Gender social transition refers to a process by which a child is acknowledged by others and has the opportunity to live publicly, either in all situations or in certain situations, in the gender identity they affirm and has no singular set of parameters or actions (Ehrensaft et al., 2018).

Gender social transition has often been conceived in the past as binary—a girl transitions to a boy, a boy to a girl. The concept has expanded to include children who shift to a nonbinary or individually shaped iteration of gender identity (Chew et al., 2020; Clark et al., 2018). Newer research indicates the social transition process may serve a protective function for some prepubescent children and serve to foster positive mental health and well-being (Durwood et al., 2017; Gibson et al., 2021; Olson et al., 2016). Thus, recognition that a child's gender may be fluid and develop over time (Edwards-Leeper et al., 2016; Ehrensaft, 2018; Steensma, Kreukels et al., 2013) is not sufficient justification to negate or deter social transition for a prepubescent child when it would be beneficial. Gender identity evolution may continue even after a partial or complete social transition process has taken place (Ashley, 2019e; Edwards-Leeper et al., 2018; Ehrensaft, 2020; Ehrensaft et al., 2018; Spivey & Edwards-Leeper, 2019). Although empirical data remains limited, existing research has indicated children who are most assertive about their gender diversity are most likely to persist in a diverse gender identity across time, including children who socially transition prior to puberty (Olson et al., 2022; Rae et al., 2019; Steensma, McGuire et al., 2013). Thus, when considering a social transition, we suggest parents/caregivers and HCPs pay particular attention to children who consistently and often persistently articulate a gender identity that does not match the sex designated at birth. This includes those children who may explicitly request or desire a social acknowledgement of the gender that better matches the child's articulated gender identity and/or children who exhibit distress when their gender as they know it is experienced as incongruent with the sex designated at birth (Rae et al., 2019; Steensma, Kreukels et al., 2013).

Although there is a dearth of empirical literature regarding best practices related to the social transition process, clinical literature and expertise provides the following guidance that prioritizes a child's best interests (Ashley, 2019e; Ehrensaft, 2018; Ehrensaft et al., 2018; Murchison et al., 2016; Telfer et al., 2018): 1) social transition should originate from the child and reflect the child's wishes in the process of making the

decision to initiate a social transition process; 2) an HCP may assist exploring the advantages/benefits, plus potential challenges of social transition; 3) social transition may best occur in all or in specific contexts/settings only (e.g., school, home); and 4) a child may or may not choose to disclose to others that they have socially transitioned, or may designate, typically with the help of their parents/caregivers, a select group of people with whom they share the information.

In summary, social transition, when it takes place, is likely to best serve a child's well-being when it takes place thoughtfully and individually for each child. A child's social transition (and gender as well) may evolve over time and is not necessarily static, but best reflects the cross-section of the child's established self-knowledge of their present gender identity and desired actions to express that identity (Ehrensaft et al., 2018).

A social transition process can include one or more of a number of different actions consistent with a child's affirmed gender (Ehrensaft et al., 2018), including:

- Name change;
- Pronoun change;
- Change in sex/gender markers (e.g., birth certificate; identification cards; passport; school and medical documentation; etc.);
- Participation in gender-segregated programs (e.g., sports teams; recreational clubs and camps; schools; etc.);
- Bathroom and locker room use;
- Personal expression (e.g., hair style; clothing choice; etc.);
- Communication of affirmed gender to others (e.g., social media; classroom or school announcements; letters to extended families or social contacts; etc.).

#### Statement 7.13

**We recommend health care professionals and parents/caregivers support children to continue to explore their gender throughout the pre-pubescent years, regardless of social transition.**

It is important children who have engaged in social transition be afforded the same opportunities as other children to continue considering

meanings and expressions of gender throughout their childhood years (Ashley 2019e; Spencer, Berg et al., 2021). Some research has found children may experience gender fluidity or even detransition after an initial social transition. Research has not been conclusive about when in the life span such detransition is most likely to occur, or what percentage of youth will eventually experience gender fluidity and/or a desire to detransition—due to gender evolution, or potentially other reasons (e.g., safety concerns; gender minority stress) (Olson et al., 2022; Steensma, Kreukels et al., 2013). A recent research report indicates in the US, detransition occurs with only a small percentage of youth five years after a binary social transition (Olson et al., 2022); further follow-up of these young people would be helpful. Replication of these findings is important as well since this study was conducted with a limited and self-selected participant pool in the US and thus may not be applicable to all gender diverse children. In summary, we have limited ability to know in advance the ways in which a child's gender identity and expressions may evolve over time and whether or why detransition may take place for some. In addition, not all gender diverse children wish to explore their gender (Telfer et al., 2018). Cisgender children are not expected to undertake this exploration, and therefore attempts to force this with a gender diverse child, if not indicated or welcomed, can be experienced as pathologizing, intrusive and/or cisnormative (Ansara & Hegarty, 2012; Bartholomaeus et al., 2021; Oliphant et al., 2018).

#### Statement 7.14

**We recommend health care professionals discuss the potential benefits and risks of a social transition with families who are considering it.**

Social transition in prepubescent children consists of a variety of choices, can occur as a process over time, is individualized based on both a child's wishes and other psychosocial considerations (Ehrensaft, 2018), and is a decision for which possible benefits and challenges should be weighted and discussed.

A social transition may have potential benefits as outlined in clinical literature (e.g., Ehrensaft et al., 2018) and supported by research (Fast &

Olson, 2018; Rae et al., 2019). These include facilitating gender congruence while reducing gender dysphoria and enhancing psychosocial adjustment and well-being (Ehrensaft et al., 2018). Studies have indicated socially transitioned gender diverse children largely mirror the mental health characteristics of age matched cisgender siblings and peers (Durwood et al., 2017). These findings differ markedly from the mental health challenges consistently noted in prior research with gender diverse children and adolescents (Barrow & Apostle, 2018) and suggest the impact of social transition may be positive. Additionally, social transition for children typically can only take place with the support and acceptance of parents/caregivers, which has also been demonstrated to facilitate well-being in gender diverse children (Durwood et al., 2021; Malpas et al., 2018; Pariseau et al., 2019), although other forms of support, such as school-based support, have also been identified as important (Durwood et al., 2021; Turban, King et al., 2021). HCPs should discuss the potential benefits of a social transition with children and families in situations in which 1) there is a consistent, stable articulation of a gender identity that is incongruent with the sex assigned at birth (Fast & Olson, 2018). This should be differentiated from gender diverse expressions/behaviors/interests (e.g., playing with toys, expressing oneself through clothing or appearance choices, and/or engaging in activities socially defined and typically associated with the other gender in a binary model of gender) (Ehrensaft, 2018; Ehrensaft et al., 2018); 2) the child is expressing a strong desire or need to transition to the gender they have articulated as being their authentic gender (Ehrensaft et al., 2018; Fast & Olson, 2018; Rae et al., 2019); and 3) the child will be emotionally and physically safe during and following transition (Brown & Mar, 2018). Prejudice and discrimination should be considerations, especially in localities where acceptance of gender diversity is limited or prohibited (Brown & Mar, 2018; Hendricks & Testa, 2012; Turban, King et al., 2021). Of note, there can also be possible risks to a gender diverse child who does not socially transition, including 1) being ostracized or bullied for being perceived as not conforming to prescribed community

gender roles and/or socially expected patterns of behavior; and 2) living with the internal stress or distress that the gender they know themselves to be is incongruent with the gender they are being asked to present to the world.

To promote gender health, the HCP should discuss the potential challenges of a social transition. One concern often expressed relates to fear that a child will preclude considering the possible evolution of their gender identity as they mature or be reluctant to initiate another gender transition even if they no longer feel their social transition matches their current gender identity (Edwards-Leeper et al., 2016; Ristori & Steensma, 2016). Although limited, recent research has found some parents/caregivers of children who have socially transitioned may discuss with their children the option of new gender iterations (for example, reverting to an earlier expression of gender) and are comfortable about this possibility (Olson et al., 2019). Another often identified social transition concern is that a child may suffer negative sequelae if they revert to the former gender identity that matches their sex designated at birth (Chen et al., 2018; Edwards-Leeper et al., 2019; Steensma & Cohen-Kettenis, 2011). From this point of view, parents/caregivers should be aware of the potential developmental effect of a social transition on a child.

HCPs should provide guidance to parents/caregivers and supports to a child when a social gender transition is being considered or taking place by 1) providing consultation, assessment, and gender supports when needed and sought by the parents/caregivers; 2) aiding family members, as needed, to understand the child's desires for a social transition and the family members' own feelings about the child's expressed desires; 3) exploring with, and learning from, the parents/caregivers whether and how they believe a social transition would benefit their child both now and in their ongoing development; 4) providing guidance when parents/caregivers are not in agreement about a social transition and offering the opportunity to work together toward a consistent understanding of their child's gender status and needs; 5) providing guidance about safe and supportive ways to disclose their child's social transition to others and to facilitate their child transitioning in their various social environments (e.g., schools,

extended family); 6) facilitating communication, when desired by the child, with peers about gender and social transition as well as fortifying positive peer relationships; 7) providing guidance when social transition may not be socially accepted or safe, either everywhere or in specific situations, or when a child has reservations about initiating a transition despite their wish to do so; there may be multiple reasons for reservations, including fears and anxieties; 8) working collaboratively with family members and MHPs to facilitate a social transition in a way that is optimal for the child's unfolding gender development, overall well-being, and physical and emotional safety; and 9) providing psychoeducation about the many different trajectories the child's gender may take over time, leaving pathways open to future iterations of gender for the child, and emphasizing there is no need to predict an individual child's gender identity in the future (Malpas et al., 2018).

All of these tasks incorporate enhancing the quality of communication between the child and family members and providing an opportunity for the child to be heard and listened to by all family members involved. These relational processes in turn facilitate the parents/caregivers' success in making informed decisions about the advisability and/or parameters of a social transition for their child (Malpas et al., 2018).

One role of HCPs is to provide guidance and support in situations in which children and parents/caregivers wish to proceed with a social transition but conclude that the social environment would not be accepting of those choices, by 1) helping parents/caregivers define and extend safe spaces in which the child can express their authentic gender freely; 2) discussing with parents/caregivers ways to advocate that increase the likelihood of the social environment being supportive in the future, if this is a realistic goal; 3) intervening as needed to help the child/family with any associated distress and/or shame brought about by the continued suppression of authentic gender identity and the need for secrecy; and 4) building both the child's and the family's resilience, instilling the understanding that if the social environment is having difficulty accepting a child's social transition and affirmed gender identity, it is not because of some shortcoming in the child but because of